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Rebecca L. Rausch*

Health Cover(age)ing

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There is perhaps no greater fiction in the United States than the idea that we are worried about being fat because of its implications for our health [I]t is not because our obesity actually represents a verifiable health threat. Rather, it is because we are afraid of fat.¹

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* Visiting Assistant Professor, Seattle University School of Law; LL.M., University of California, Berkeley, School of Law, 2011; J.D., Northeastern University School of Law, 2004; B.A., Brandeis University, 2001. For their insightful comments and suggestions at various stages of this Article's development, I wish to thank Stephen D. Sugarman, Kathryn Abrams, Dean Spade, Charlotte Garden, Diane Lourdes Dick, Heidi Bond, James Puckett, and Susan P. Sturm. Special thanks to my husband, Lior Barnoon.

1. J. ERIC OLIVER, *FAT POLITICS: THE REAL STORY BEHIND AMERICA'S OBESITY EPIDEMIC* 76 (2006); see also Pat Lyons, *Prescription for Harm: Diet Industry Influence, Public Health Policy, and the "Obesity Epidemic,"* in *THE FAT STUDIES READER* 75, 75 (Esther Rothblum & Sondra Solovay eds., 2009) ("Fear of fat is not new").

I. INTRODUCTION

Fearing fatness² blinds America from certain realities of body size, health status, and access to health care. American society, through the health care system and other mechanisms, has created a fat-thin dichotomy within which thin is good and fat is bad.³ Recently, employers began reinforcing this dichotomy by imposing on employees whose weight renders them “obese” on the Body Mass Index (BMI) certain additional health insurance costs—referred to herein as health insurance fat taxes.⁴ Stated otherwise, if an employee’s BMI exceeds the employer-prescribed limit, that employee must pay more for health insurance than his or her thin colleagues, unless the fat employee attempts to slim down or provides the employer with a doc-

2. This Article employs the terms “fat” and “fatness” instead of “obesity” or “overweight” in an attempt both to reclaim the word “fat” and to avoid constant indirect support for the medicalization of fatness. See, e.g., ANNA KIRKLAND, *FAT RIGHTS: DILEMMAS OF DIFFERENCE AND PERSONHOOD* ix (2008); Deborah L. Rhode, *The Injustice of Appearance*, 61 *STAN. L. REV.* 1033, 1036 (2009). Use of the words “obese,” “morbidly obese,” and the like is intended to specifically reference a Body Mass Index category. See Rhode, *supra*, at 1036. Hopefully, these terms appear only when necessary to the analysis.

3. See DEBORAH L. RHODE, *THE BEAUTY BIAS* *passim* (2010).

4. To be fair, the additional costs that employers impose on fat employees for their health insurance are not truly taxes. Taxes are fees or charges imposed by the government on people and other entities for purposes of raising public revenue. See F. P. Ramsey, *A Contribution to the Theory of Taxation*, 37 *ECON. J.* 47, 47 (1927); Alvin C. Warren, Jr., Comment, *Fairness and a Consumption-Type or Cash Flow Personal Income Tax*, 88 *HARV. L. REV.* 931, 932 (1975) (quoting William Andrews, *A Consumption-Type or Cash Flow Personal Income Tax*, 87 *HARV. L. REV.* 1113, 1165–66 (1974)). Taxes frequently apply to particular population groups—for example, wage-earners. Similarly, health insurance fat taxes apply to a particular segment of people, for example, those whose BMIs are too high. With the advent of mandatory health insurance and the increasing popularity among employers to charge more for fat people to access health coverage, as discussed herein, these higher charges essentially function like a tax—they are universal charges applicable to everyone in the target population group. Cf. Alice G. Abreu, *Taxes, Power, and Personal Autonomy*, 33 *SAN DIEGO L. REV.* 1, 4–6, 9–12 (1996); Alice G. Abreu, *Untangling Tax Reform: Simple Taxes, Complex Choices*, 33 *SAN DIEGO L. REV.* 1355, 1377–78 (1996). Indeed, one noted scholar identifies the mandatory union membership of the 1950s and the unions’ collective bargaining for health insurance through employment as a “private tax system”:

The union shop, which in the early fifties made union membership mandatory for over two thirds of the production work force, enabled the unions to establish a “private fiscal system” able to levy a “tax” for health insurance. The government supported this private tax system by making employers’ contributions into it exempt from the government’s own taxes. Private voluntary insurance was neither strictly voluntary, nor strictly private, but its compulsory and public features were hardly noticed.

PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 334 (1982). With the individual mandate, the private tax system is now becoming more of a widespread reality.

tor's note stating that the weight cannot be lost.⁵ Employers use these health insurance fat taxes to unevenly pass through to employees the costs of health insurance coverage, in an effort to reduce their own contributory costs for that insurance.⁶ Simultaneously, employers reduce the insurance costs for thin employees who do not, at least based on their body sizes, drive up the overall costs.⁷

Essentially, health insurance fat taxes increase the costs of fatness. Those costs, however, are not limited to budgetary bottom lines. Fatness carries a heavy weight of systemic stigma.⁸ Fat individuals are viewed as lazy, slovenly, and lacking self-control.⁹ In general, fat people earn less money, find love less frequently, and feel more self-loathing than their thinner counterparts.¹⁰ They regularly suffer through tormenting and teasing at schools, places of work, and the grocery store.¹¹ The costs of fatness run deep.

Rather than contributing to a solution, health insurance fat taxes contribute to the problems by imposing both overt and covert penalties for fatness. The overt financial and access repercussions speak for themselves. Covertly, health insurance fat taxes force fat individuals to cover¹² their fatness. Professor Kenji Yoshino describes covering as one of three methods of forced assimilation, the other two—converting and passing—being slightly better known.¹³ Converting occurs when an individual is socially required to fundamentally change an underlying identity.¹⁴ Passing occurs when an individual maintains the underlying identity, but is socially required to hide it.¹⁵ Covering occurs when an individual acknowledges and embraces the underlying identity, but is socially required to make that underlying identity easier for others to ignore.¹⁶ “Covering means the underlying identity is neither altered nor hidden, but is downplayed. Covering occurs when a lesbian both is and says she is a lesbian, but otherwise makes it easy for others to disattend her orientation.”¹⁷ Covering is systemically problematic for at least three reasons: first, it creates and reinforces social norms about people's identities; second, it undermines individuals' senses of self and self-worth; and third, it misplaces focus on a

5. See *infra* section II.B.

6. See *infra* section II.B.

7. See *infra* section II.B.

8. See OLIVER, *supra* note 1, at 72–76; Rhode, *supra* note 2, at 1037–41.

9. See, e.g., RHODE, *supra* note 3, at 29.

10. See, e.g., *id.* at 26–27.

11. See, e.g., SONDRÁ SOLOVAY, TIPPING THE SCALES OF JUSTICE: FIGHTING WEIGHT-BASED DISCRIMINATION 25 (2000).

12. See Kenji Yoshino, *Covering*, 111 YALE L.J. 769 (2002).

13. *Id.* at 772.

14. See *id.*

15. See *id.*

16. See *id.*

17. *Id.*

singular component of people's identities when identities are rarely that simple.¹⁸ As will be explained further in Parts IV and V, this Article posits that health insurance fat taxes force fat individuals to cover their fatness by mandating an implicit acknowledgement that fat is bad and unhealthy. To escape the financial penalties, fat people must either follow a weight loss program, attempting to convert but probably failing,¹⁹ or state that their fatness is beyond their control, rendering them helpless and victimized. Health insurance fat taxes do not hit fat people only in their wallets. This developing regime also strikes at personhood and identity by requiring fat individuals to admit and embrace the socially constructed vision of their bodies as plainly wrong.

These health insurance fat taxes classify individuals as good or bad, desirable or objectionable, rewarded or penalized, because of an identified health status factor that is evaluated on a scale having no basis in medical science and that might be wholly arbitrary vis-à-vis actual health.²⁰ As will be discussed, scientists dispute the causes of fatness. One school of thought believes that fatness is a disease caused by genetics and other biologics, rendering fatness basically immutable.²¹ Another school of thought believes that fatness is wholly mutable, caused not by biology but by choice and environmental factors, such as sedentary lifestyles and diets too rich in calorie-dense foods.²² The truth probably lies somewhere between these two extremes, involving both nature and nurture, but that truth currently escapes modern science. Assuming such a combination of causes, health insurance fat taxes both penalize for an immutable characteristic (nature) and make the health care system more difficult for fat people to access by increasing coverage costs, which access they arguably need in order to change their body size (nurture). As discussed in Part III, the health care system presents fiscal, social, and emotional challenges for fat people; making the system even harder to access seems to miss the public policy mark.

In addition, the effects of fatness are more complex than modern medical science can yet fully appreciate.²³ Perhaps fatness causes diabetes, coronary artery disease, and other health problems. Conversely, perhaps fatness is merely a symptom of other conditions that standing alone has no causal relationship with overall health, despite any apparent correlative relationships. Fat people can have normal

18. Cf. Eli Clare, *Resisting Shame: Making Our Bodies Home*, 8 SEATTLE J. SOC. JUST. 455, 457–61 (2010); Russell K. Robinson, *Uncovering Covering*, 101 NW. U. L. REV. 1809, 1815–25 (2007); Yoshino, *supra* note 12, at 781.

19. Studies show that up to 95% of diets fail. See Lyons, *supra* note 1, at 77.

20. See, e.g., RHODE, *supra* note 3, at 24–25; *infra* section III.A.

21. See *infra* section III.B.

22. See *infra* section III.B.

23. See *infra* section III.A.

cholesterol counts, blood pressure, and blood sugar levels, but they are nonetheless financially penalized for their fatness under the health insurance fat tax regime. Either way, this new regime is flawed. If fatness causes other health problems, then fat people are precisely the ones who should be accessing the health care system, and yet they are also the ones who, because of health insurance fat taxes, face additional obstacles on their way to that system to manage their condition. Alternatively, if fatness is a symptom of something else and on its own yields no serious health consequences, then the penalty arises out of an arbitrary and irrelevant physical characteristic.

While the science can be debated, at bottom, the science bears limited relevance to the underlying argument set forth herein. Why choose fatness as the predominant identifier of increased health access costs? The answer must be that America fears fat; no similar access cost increase exists for the underweight, even though that body size can lead to significant health detriments and drive up the cost of care.²⁴ Further, where the public policy goal is to encourage people to be healthier, imposing health insurance fat taxes is a poor methodological choice.

Though uneven costs based on an arbitrarily selected physical feature might seem discriminatory, health insurance fat taxes are perfectly legal under federal law. The Americans with Disabilities Act of 1990²⁵ (ADA) and Title VII of the Civil Rights Act of 1964²⁶ (Title VII) generally do not protect people because of their fatness.²⁷ The recently enacted Patient Protection and Affordable Care Act of 2010²⁸ (ACA) also allows, and encourages, this new regime to continue, under the guise of wellness programs.²⁹ Ironically, despite the name, these programs do not necessarily measure wellness, nor are they required to do so.³⁰

The legality of health insurance fat taxes generates another set of questions, namely, why the law functions in this particular way and

24. See, e.g., Katherine M. Flegal et al., *Excess Deaths Associated With Underweight, Overweight, and Obesity*, 293 J. AMER. MED. ASSOC. 1861 (2005); RHODE, *supra* note 3, at 41 ("Recent research finds that moderately overweight individuals have the lowest mortality rates of any weight group; thin individuals who match cultural ideals have the highest rates. Low body weight compromises reproductive and work capacity, and predicts a greater frequency of sickness." (citation omitted)).

25. 42 U.S.C. §§ 12101–12213 (2006).

26. 42 U.S.C. §§ 2000e–2000e-17 (2006).

27. See *infra* section V.A.

28. Pub. L. No. 111-148, § 1201(4), 124 Stat. 119, 154 (2010).

29. See *infra* section V.B. The wellness program provisions are also known as the Safeway Amendment. See Kristin M. Madison et al., *The Law, Policy and Ethics of Employers' Use of Financial Incentives to Improve Health*, 39 J.L. MED. & ETHICS 450, 451 (2011).

30. See *infra* section V.B.

whether it should function differently. This Article posits that the current functionality reflects a different type of covering, by which society forces itself to make certain of its underlying identities—in this case, anti-fat bias—a little less obvious. While this is not the individualized covering Professor Yoshino originally discussed,³¹ this Article attempts to expand upon that conception. As a whole, society avoids admitting that its shortcomings, such as anti-fat bias, exist. Collective society pushes to cover its collective flaws. Specifically, systemic fear of fatness and losing the currency ascribed to thinness allows the law to permit and promote the existence and expansion of this new regime. Health insurance fat taxes exemplify the concept of what will be termed herein collective cover-up.

Part II explores fatness and health insurance, focusing on the contrast between the traditional communitarian health care model and health insurance fat taxes. This Part also details various health insurance fat tax programs either implemented or proposed across the country. Part III critiques the science of fatness, manifested through BMI, and the construction of fatness as a disease. Part IV discusses the systemic implications of fatness and draws certain parallels between social treatments of fatness and queerness. These parallels provide a useful basis for applying Professor Yoshino's covering theory to fatness. Part V examines legal regimes that generally seem as if they might prohibit the anti-fat discrimination of health insurance fat taxes, but do not. Using these legal regimes as a lens, Part V then explores the expansion of covering to the whole of society and the ways in which fatness begets collective cover-up. Finally, Part VI offers some concluding thoughts and questions about how the law might push social norms such that anti-fat discrimination could become less pervasive and public health goals might be better achieved.

II. FATNESS AND HEALTH INSURANCE

Health care finance in America grew from a community-based model; in today's group market, usually people do not pay extra for insurance coverage based on health status. Health insurance fat taxes, however, change that paradigm. This Part provides a historical perspective on the American communitarian health care model, followed by detailed descriptions of health insurance fat taxes and similar schemes, which schemes represent a notable shift away from that communitarian model.

31. Yoshino, *supra* note 12.

A. The Communitarian Model of Health Care

The foundation of our health care finance system rests upon communitarian ideals.³² American health insurance plans originated in the period following the Great Depression as a method of creating a more reliable flow of payment to hospitals for services rendered.³³ These hospital-sponsored health plans, which eventually became the Blue Cross plans, operated on a community rating system through which each plan beneficiary paid the same premium costs, determined based on geography, irrespective of the beneficiary's other health status factors.³⁴ These hospital plans quickly gained popularity and by 1937, one million people were covered.³⁵ Physicians saw the success of the Blue Cross hospital plans and soon created similar Blue Shield plans, also operated on a community rating basis.³⁶

While most of the early Blue Cross and Blue Shield beneficiaries enrolled individuals or groups based on geographic communities, the health insurance enrollment system soon shifted to an employer-based model, creating communities through the workplace.³⁷ In 1954, the Internal Revenue Service overhauled the tax code such that employer contributions to health insurance premium costs, as a non-taxable form of compensation and a claimed business expense for employers, became more cost-effective than other forms of employee compensation.³⁸ In light of the tax and other incentives for employers, including rebates offered by commercial insurers, by the late 1950s, health insurance was a standard component of employee compensation packages offered by most major employers.³⁹ Rates of employee enrollment in employer-sponsored health insurance continued to rise,⁴⁰ reaching a peak of 66.8% enrollment of non-elderly Americans in 2000.⁴¹ Though employer-sponsored insurance enrollment

32. See Mark Schlesinger, *Paradigms Lost: The Persisting Search for Community in U.S. Health Policy*, 22 J. HEALTH POL., POL'Y & L. 937, 938–39, 948–49, 950 (1997).

33. Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J. LAW, MED. & ETHICS 141, 143 (1993).

34. D. ANDREW AUSTIN & THOMAS L. HUNGERFORD, CONG. RESEARCH SERV., R40834, *THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY* 3–4, 6 (2009), available at <http://www.fas.org/sgp/crs/misc/R40834.pdf>; Bovbjerg et al., *supra* note 33, at 143.

35. AUSTIN & HUNGERFORD, *supra* note 34, at 3.

36. Bovbjerg et al., *supra* note 33, at 143.

37. AUSTIN & HUNGERFORD, *supra* note 34, at 6.

38. *Id.* at 5; Bovbjerg et al., *supra* note 33, at 145.

39. AUSTIN & HUNGERFORD, *supra* note 34, at 5–6.

40. Cf. Jill Quandagno, *Physician Sovereignty and the Purchasers' Revolt*, 29 J. HEALTH POL., POL'Y & L. 815, 824–26 (2004) (describing cost containment concerns and efforts from corporate purchasers of health insurance).

41. David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

has declined slightly since the peak, more than half of non-elderly Americans still obtain coverage through this method.⁴² The number of non-elderly Americans who purchase insurance through their employers will remain nearly constant after implementation of the ACA's Health Insurance Exchanges (HIEs) through which both employed and unemployed individuals may purchase insurance coverage.⁴³

Both the employer-sponsored plans and the HIEs will continue the practice of community rating in some form.⁴⁴ Essentially, community rating "is a method of pooling risks so that the financial burden of medical care is distributed among many people. . . . [M]oney is shifted from those who remain healthy to those who become sick or injured."⁴⁵ In a pure community rating system, such as the original hospital-based insurance plans created in the 1930s, premium costs are set by geographic location only, without consideration of other demographic or health factors.⁴⁶ The current U.S. health insurance market per-

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42. *The Uninsured*, HENRY J. KAISER FAMILY FOUND. 1 (Dec. 2010), <http://www.kff.org/uninsured/upload/7451-06.pdf>; Diane Rowland et al., *Focus on Health Reform: Health Care and the Middle Class*, HENRY J. KAISER FAMILY FOUND. 3-4 (July 2009), <http://www.kff.org/healthreform/upload/7951.pdf>. The elderly population (age 65 and over) is excluded from these measurements because most of this segment of the population is covered by Medicare. Rowland et al., *supra*, at 3. The statistics focus on the population that would normally be purchasing insurance. *Id.*
 43. See CONG. BUDGET OFFICE, ANALYSIS OF THE MAJOR HEALTH CARE LEGISLATION ENACTED IN MARCH 2010 1-2 (2011), available at <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf>; CONG. BUDGET OFFICE, ESTIMATE OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS CONTAINED IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PUBLIC LAW 111-148) AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152) 1 (2011), available at <http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceProvisions.pdf>; PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 239 (2011); *The Uninsured*, *supra* note 42, at 24; Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Hon. Nancy Pelosi, Speaker, U.S. House of Representatives, at 9-10, app. tbl.4 (Mar. 20, 2011), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.
 44. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1252, 124 Stat. 119, 162 (2010) (to be codified at 42 U.S.C. § 18012) (creating the HIEs); AUSTIN & HUNGERFORD, *supra* note 34, at 52 (discussing the use of cooperative health insurance policies, which would be available to eligible individuals through HIEs created by health insurance reform legislation); see also Stephen D. Sugarman, "Lifestyle" Discrimination in Employment, 24 BERKELEY J. EMP. & LAB. L. 377, 412 (2003) (arguing that differential pricing for health insurance premiums may be against the interests of employers, and even if that differential premium is practically valuable, social externalities may preclude realistic value).
 45. AUSTIN & HUNGERFORD, *supra* note 34, at 11; see also STARR, *supra* note 4, at 329-30 ("community rates keep down costs for high-risk groups").
 46. See *Consumer Guide to Group Health Insurance*, NAT'L ASS'N OF HEALTH UNDERWRITERS, <http://nahu.org/consumer/GroupInsurance.cfm> (last visited Apr. 28, 2011) [hereinafter NAHU]; *supra* notes 34-36 and accompanying text.

petuates certain hybrid models that incorporate both community and experience rating components.⁴⁷

Under one option, sometimes referred to as “modified” or “adjusted” community rating, insurers offering plans to small employers base the premium rates on geographic location (pure community rating) plus claims history and certain demographic and employee health factors—such as age, gender, and smoker status (experience rating elements).⁴⁸ With medical underwriting, another plan option for small employers, insurers determine premium rates based on the health statuses of employees and their covered family members; states have injected solidarity ideals of community rating into medical underwriting through a regulatory control mechanism called rating bands.⁴⁹ Similarly, insurers medically underwrite large employer groups based on the level of employee participation (but not their health statuses) and prior claims history of the group.⁵⁰ So for large and small employers alike, groups with greater health risks and claim rates pay more, collectively, than groups with lower risks and claim rates, but all members of a group typically pay the same premium rates into the collective insurance pool.⁵¹ These hybrid rating systems group people together (whether by employer or by exchange) and insurers estimate the medical expenses that will be incurred by the group at large, rather than specific individuals’ medical costs.⁵² Insurers then charge the whole group a particular amount for coverage and that amount is

47. In an experience rating system, insurance premium costs are set based on actuarial assessments of demographics (such as age, sex, and geographic location), past claims history, specific risks of a particular type of employment (such as construction work or logging), and health status factors of particular individuals. For a general description of the distinctions between community rating and experience rating, see STARR, *supra* note 4, at 329–31.

48. See NAHU, *supra* note 46.

49. *Id.*; see NAT’L ASS’N OF INS. COMM’RS & CTR. FOR INS. POLICY AND RESEARCH, RATE REGULATION (2011), available at http://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf. Under rating band regulation, a particular group’s premium rates may not vary by more than a specified percentage of the average small group premium rate. *Id.* For example, if the average small group rate is \$100 per month and the rating band is plus or minus 25%, then any small group’s rate may be as low as \$75 per month or as high as \$125 per month.

50. NAHU, *supra* note 46.

51. See, e.g., Alan C. Monheit et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFF. 167, 168 (2004); Wendy K. Zellers et al., *Small-Business Health Insurance: Only the Healthy Need Apply*, 11 HEALTH AFF. 174, 174–75, 177 (1992). Interestingly, other factors might also contribute to higher costs for particular groups. Lawyers and physicians, for example, might pay more or be excluded from certain health plans entirely because, as groups, they are too litigious and have high utilization rates, respectively. Zellers et al., *supra*, at 176–77. Cost differentials are even more exaggerated in a pure experience rating system. See AUSTIN & HUNGERFORD, *supra* note 34, at 6.

52. See, e.g., AUSTIN & HUNGERFORD, *supra* note 34, at 11, 17–18; Uwe E. Reinhardt, *Is ‘Community Rating’ in Health Insurance Fair?*, ECONOMIX (Jan. 1, 2010, 7:01

divided—usually equally—among all of the group members (i.e., the employees or HIE purchasers) such that each member pays the same health insurance premium, consistent with the communitarian model.⁵³

Perhaps not surprisingly, the communitarian model can be polarizing. Some argue that community rating systems are unfair because low-risk individuals pay more than their proportional share of the premiums, while high-risk individuals pay too little.⁵⁴ Others argue that this model represents the essence of a communal society—or, at least, what that essence should be. Professor Deborah Stone described this essence as the “solidarity principle,” meaning that as a collective society, “we should not abandon those who are sick or attached in some way to people who are sick; sick and healthy, we are all one community.”⁵⁵

Many things go into the making of community. Communities share a common culture and a way of perpetuating it. They establish processes for governance, conflict resolution, and self-defense. Above all, the people in a community help each other. Mutual aid among a group of people who see themselves as sharing common interests is the essence of community; a willingness to help each other is the glue that holds people together as a society, whether at the level of a simple peasant community . . . or a modern welfare state.⁵⁶

AM), <http://economix.blogs.nytimes.com/2010/01/01/is-community-rating-in-health-insurance-fair>.

53. AUSTIN & HUNGERFORD, *supra* note 34, at 11, 17–18; Reinhardt, *supra* note 52. Employers frequently contribute to the insurance premium costs for their employees, as a form of compensation. See AUSTIN & HUNGERFORD, *supra* note 34, at 5–6.

54. See, e.g., Monheit et al., *supra* note 51, at 168; Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y AND L. 287, 287–88 (1993) (describing an ad campaign of the late 1980s sponsored by the health and life insurance trade associations). This vision commits itself to actuarial fairness and accuracy, such that people pay for what they use. See Stone, *supra*, at 288–89.

55. Stone, *supra* note 54, at 289.

56. *Id.* A variety of other countries operate health care systems consistent with the solidarity principle. Uwe E. Reinhardt, *How the World Balances Health Care Risk*, ECONOMIX (Jan. 8, 2010, 7:07 AM), <http://economix.blogs.nytimes.com/2010/01/08/how-the-world-balances-health-care-risk>. Switzerland, the Netherlands, and Germany all maintain community rating with widespread popular acceptance—even societal expectation—and all three countries offer their citizens an array of private health insurers (not governmentally operated) from which to choose. *Id.* Similar systems operate in Canada, Australia, New Zealand, Japan, and numerous other countries. *Id.* According to Professor Uwe Reinhardt, these community rating systems continue because “[t]he vast majority of citizens in these countries view health care as a ‘social good’ that is to be shared on the basis of need by all on roughly equal terms and is to be financed largely on the basis of ability to pay.” *Id.* Professor Reinhardt is the James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University. Uwe E. Reinhardt, PRINCETON UNIV., <http://www.princeton.edu/~reinhard/> (last visited Oct. 16, 2011).

As described above, the underlying solidarity sentiment of community rating maintains a certain presence in today's U.S. health care financing.⁵⁷ At the turn of the millennium, more than half of Americans supported collective responsibility for medical care.⁵⁸ Numerous scholars have analyzed, critiqued, and evaluated the extent to which the solidarity principle should be applied to the American health care system and the bounds of American distributive health justice.⁵⁹ The existence of this scholarly discourse demonstrates that the communitarian health care model persists in the U.S. The creation of the HIEs, pursuant to the ACA,⁶⁰ evidences a continued commitment to these communitarian principles. In general, for more than half of non-elderly Americans who purchase insurance through their employers, the insurer assesses the collective risk and determines a total premium amount, and the employer determines how much of that premium it will pay on behalf of each employee as part of the compensation package with the remainder of the costs divided evenly among its employees.⁶¹ Americans participate in a solidarity-type system,

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57. See Jeffrey W. Stempel, *Adam, Martin and John: Iconography, Infrastructure, and America's Pathological Inconsistency About Medical Insurance*, 14 CONN. INS. L.J. 229, 260–61 (2008); see also Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1328–30, 1336–39 (1995) (describing communitarian theory and applying that theory to the U.S. health care system).
 58. See Madison et al., *supra* note 29, at 454 (“[A] national poll found that more people think it is unfair (42%) than fair (37%) ‘to ask people with unhealthy lifestyles to pay higher insurance premiums than people with healthy lifestyles.’”); Mark Schlesinger, *Reprivatizing the Public Household? Medical Care in the Context of American Public Values*, 29 J. HEALTH POL., POL’Y & L. 969 *passim* (2004).
 59. See, e.g., NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* (2008); NORMAN DANIELS, *JUST HEALTH CARE* (1985); NORMAN DANIELS, *SEEKING FAIR TREATMENT: FROM THE AIDS EPIDEMIC TO NATIONAL HEALTH CARE REFORM* (1995); RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1997); IN SEARCH OF EQUITY: *HEALTH NEEDS AND THE HEALTH CARE SYSTEM* (Ronald Bayer et al. eds., 1983); JOHN RAWLS, *A THEORY OF JUSTICE* (rev. ed. 1999); JOHN RAWLS, *JUSTICE AS FAIRNESS: A RESTATEMENT* 168–76 (2003); Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L. REV. 108, 131–35 (1996); Norman Daniels et al., *Benchmarks of Fairness for Health Care Reform*, WORLD HEALTH ORG. (1996), [www.who.int/bulletin/archives/78\(6\)740.pdf](http://www.who.int/bulletin/archives/78(6)740.pdf).
 60. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289 (2010).
 61. Some employer-sponsored health insurance plans, such as the one for the University of California, take a slightly different approach and differentiate premium amounts based on salary. See, e.g., *Information for UC Employees Regarding UC's 2007 Medical Plan Bid Process*, UNIV. OF CAL., http://atyourservice.ucop.edu/news/health/2007_medical_bid.html (last visited Oct. 17, 2011) (noting that the University of California will “continu[e] its salary-based approach to monthly premiums, which . . . means lower-paid workers pay lower monthly premiums and continue to have access to quality health insurance for themselves and their families”). This premium distinction arguably fits into the communitarian model even more so than the flat rate model because it attempts to make access to health care equitable across class lines.

consistent with the communitarian model, which relies on collective contributions and distributions to those who need.

B. An Anti-Communitarian Development: Health Insurance Fat Taxes

Recently, however, employers began shirking away from communitarian and solidarity principles by charging certain employees uneven shares of their group insurance premiums or otherwise increasing the cost of health care for people who fail to meet certain health status benchmarks, which failures cause overall insurance costs to rise.⁶² Fatness is one such health factor that can drive up the collective cost of insurance.⁶³ To reduce their share of increased health insurance premiums, and to avoid charging thin people more money in a tight economy, some employers now shift the additional fatness costs onto the fat employees through health insurance fat taxes.⁶⁴ These health insurance fat taxes represent a serious shift away from a solidarity, communitarian model.

Though the concept is relatively new, implementing these health insurance fat taxes may be an increasing trend among employers who sponsor health insurance plans.⁶⁵ Evidence of this trend can be found among both public and private employers.⁶⁶

1. The Alabama Program

The Alabama State Employees' Insurance Board (SEIB) made national news when it approved its "Wellness Premium Discount Program" in 2008 (the Alabama Program).⁶⁷ Through the end of fiscal year 2009, non-smoker state employees in Alabama received free health insurance as part of their employee benefits package.⁶⁸ Begin-

62. See Roni Caryn Rabin, *Could Health Overhaul Incentives Hurt Some?*, N.Y. TIMES, Apr. 13, 2010, at D5, available at <http://www.nytimes.com/2010/04/13/health/13land.html>.

63. Fatness is said to add \$90 billion to health care costs each year. Elizabeth Kolbert, *XXXL: Why Are We So Fat?*, THE NEW YORKER 73, 76–77 (July 20, 2009), available at http://www.newyorker.com/arts/critics/books/2009/07/20/090720crbo_books_kolbert?currentPage=all.

64. See *supra* note 4 (discussing the use of the term "tax" in this context).

65. Notably, most employers fall into this category, especially after the advent of the ACA, and likely this will remain so, particularly if the ACA withstands Constitutional scrutiny. See *supra* notes 39–42 and accompanying text. Cf. ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 120 (2010).

66. See *infra* subsections II.B.1–II.B.3.

67. See, e.g., Associated Press, *Alabama workers to pay extra for pounds*, MSNBC.COM (Aug. 21 2008), <http://www.msnbc.msn.com/id/26337794>.

68. *State Employees' Health Insurance Plan: Approved Premium and Benefit Changes*, ALA. ST. EMPs.' INS. BOARD. (2009) [hereinafter *Approved Premium and Benefit Changes*], <http://www.alseib.org/PDF/SEHIPFY2010RateChange.pdf>. Employees and retirees who smoke or use other tobacco products have been sub-

ning in fiscal year 2010, however, with the implementation of the new Alabama Program, all state employees pay a minimum flat fee of \$15.00 per month, which amount increases to \$40.00 (representing a 267% increase) if the employees fail to achieve certain health markers indicating “wellness.”⁶⁹ Health risk factors include, among other things, BMI of 35 or higher.⁷⁰ Worksite health screening results from 2009 indicate that of the 35,716 employees screened that year, nearly 22% fall into the BMI risk group.⁷¹ In other words, more than one in five Alabama state workers are deemed at risk because of their fatness. This risk group is nearly double the number of employees falling into all of the other risk groups combined, indicating the Program’s obvious target.⁷²

To remain eligible for the so-called “discount” under the Alabama Program, a state employee with a BMI of 35 or higher⁷³ must participate in a weight reduction program such as Weight Watchers, lose weight on their own, or provide a note from a physician indicating that the employee has a medical condition that precludes weight loss.⁷⁴ The state does not charge variable insurance premium rates based on

ject to a health insurance surcharge since October 1, 2005. *See* ALA. CODE § 36-29-19.3 (2001). William Ashmore, the SEIB Chief Executive Officer, attributes the mandatory smoker surcharge to the fact that smoking or other tobacco use is a lifestyle choice. According to Ashmore, “[y]ou either smoke or you don’t, and if you smoke, you will pay” Paul Gallagher, *Heavy Attention on Alabama Plan*, HUMAN RES. EXEC. ONLINE (Sept. 8, 2008), <http://www.hreonline.com/HRE/printstory.jsp?storyId=124846138>.

69. *Approved Premium and Benefit Changes*, *supra* note 68.

70. Ala. State Emps.’ Ins. Bd., *Wellness Premium Discount Program*, HEALTH WATCH 3 (Jan./Feb. 2011) [hereinafter HEALTH WATCH], <http://www.alseib.org/PDF/SEHIP/HWJan2011.pdf>. Other risk factors include high levels of cholesterol, glucose, and blood pressure. *Id.*

71. *State Employees’ Health Insurance Plan: Worksite Wellness Screening Results*, ALA. ST. EMPS.’ INS. BOARD. 3, 5 (2009), <http://www.alseib.org/PDF/WellnessScreeningResultsPresentation.pdf>.

72. *See id.* at 5. The wellness screening results do not provide information about any overlap between the individuals at risk in the BMI category and the individuals at risk in the other categories. *See id.* Stated otherwise, individuals may be double-counted if they fall into multiple risk groups.

73. Employees can calculate their BMIs by entering their heights and weights at the SEIB website, <http://www.alseib.org/Healthinsurance/sehip/BMICalculator.aspx>. A person who is 5 feet, 4 inches tall crosses the threshold into “overweight” at 146 pounds, which yields a BMI of 25.11. This person becomes “obese” at 175 pounds (BMI = 30.11), and “morbidly obese” at 204 pounds (BMI = 35.09). This person is “underweight” at 109 pounds (BMI = 18.5), but there are no insurance penalties for individuals who are underweight.

74. *State of Alabama: Wellness Premium Discount Program*, ALA. ST. EMPS.’ INS. BOARD § II, available at <http://www.alseib.org/PDF/SEHIP/SEHIPWellnessPremiumDiscount.pdf> (last visited Mar. 4, 2011); HEALTH WATCH, *supra* note 70.

the health statuses of employees' dependents who are covered by the same health insurance system.⁷⁵

Media coverage of the Alabama Program bifurcated into two main camps. Several articles and editorials cited by the SEIB hail the Alabama Program as a voluntary discount program through which the state seeks to improve the health of its employees—an issue of particular importance in a state ranked as one of the fattest in the nation.⁷⁶ Conversely, many articles and editorials, including some of those cited by the SEIB on its website, call the Alabama Program a penalty payment based on weight, or more bluntly, a health insurance fat tax.⁷⁷ As one columnist stated, “Big Brother has been watching and has grown weary of the proverbial carrot incentives. So, here comes the punishing stick. . . . Those in charge want citizens to step up to the plate and take personal responsibility for their fatness—or pay for the privilege to be pudgy.”⁷⁸ She recounts the Alabama Program in a rather succinct, candid fashion: “Alabama recently gave its 37,527 overweight government employees a year to slim down and shape up or be prepared to fork over [an extra] \$25 a month for health insurance”⁷⁹

75. Ala. State Emps.' Ins. Bd., *State Employees Want to Know*, HEALTH WATCH 2 (Sept./Oct. 2011), <http://www.alseib.org/PDF/SEHIP/HWOct2008.pdf>; HEALTH WATCH, *supra* note 70.

76. See, e.g., *Articles on the Wellness Premium Discount Program*, ALA. ST. EMPS.' INS. BOARD, <https://www.alseib.org/Information/Media/Articles.aspx> (last visited Mar. 5, 2011); see also JEFFREY LEVI ET AL., TRUST FOR AMERICA'S HEALTH, F AS IN FAT: HOW OBESITY POLICIES ARE FAILING IN AMERICA (2008), <http://healthyamericans.org/reports/obesity2008/Obesity2008Report.pdf> (tracking trends in obesity-related rates and policies in the United States).

77. See Erin Anderssen, *Fighting Obesity: The Wrong Way vs. The Right Way*, THE GLOBE AND MAIL (CANADA), Jan. 15, 2011, at F1 (“Alabama decided that its state employees should pay a \$25-a-month fat penalty for health insurance that is free to the thin.”); Don Fernandez, *Alabama ‘Obesity Penalty’ Stirs Debate*, WEBMD HEALTH NEWS (Aug. 25, 2008), <http://www.webmd.com/diet/news/20080825/alabama-obesity-penalty-stirs-debate>; Victoria E. Knight, *Alabama to Obese Employees: Address the Issue, or Pay for Insurance*, HEALTH BLOG (Aug. 29, 2008, 4:01 PM), <http://blogs.wsj.com/health/2008/08/29/alabama-to-obese-employees-address-the-issue-or-pay-for-insurance>; Associated Press, *supra* note 67 (“Alabama will be the first state to charge overweight state workers who don’t work on slimming down”); Shari Roan, *Alabama to place ‘fat tax’ on obese state employees*, BOOSTER SHOTS (Aug. 25, 2008, 3:39 PM), http://latimesblogs.latimes.com/booster_shots/2008/08/alabama-places.html; Matt Sloane, *Alabama to link premium costs to workers’ health*, CNNHEALTH.COM (Dec. 9, 2008), <http://www.cnn.com/2008/HEALTH/diet.fitness/09/19/alabama.obesity.insurance/index.html>; Jana Winter, *Alabama Plans to Tax Fat Employees to Recoup Insurance Costs*, FOXNEWS.COM (Sept. 2, 2008), <http://www.foxnews.com/story/0,2933,414861,00.html>.

78. Kimberly Garrison, *Your Choice Could Be: Slim Down or Pay*, PHILADELPHIA DAILY NEWS, Aug. 28, 2008, at 35.

79. *Id.*

2. *The Arizona Proposal*

Alabama imposes financial penalties on fat employees who purchase health insurance through their state employment. Arizona, however, plans to impose financial penalties on individuals who cannot afford to purchase health insurance at all, whether through their employment or otherwise. In March 2011, Arizona Governor Jan Brewer announced her proposal that adult Medicaid beneficiaries without children be charged \$50 per year if they smoke or are fat and fail to comply with a physician's weight reduction instructions.⁸⁰ This plan, if implemented, would be the first health insurance fat tax penalizing people for "unhealthy lifestyles" imposed by a government health care program.⁸¹

Governor Brewer trumpets the proposal as an "incentive strateg[y] that will encourage individuals to take greater control of their health,"⁸² but Democratic state Senator Kyrsten Sinema believes the \$50 fee inappropriately penalizes individuals with health conditions beyond their control, including those who are fat.⁸³ Specifically, Sinema said that "[t]o fine people for medical conditions that might be beyond their control, that's just not right. . . . This would punish people with disabilities who have done nothing wrong."⁸⁴ She also stated that other people who perpetuate unhealthy behaviors, such as drinking sugar-sweetened soda, are not financially penalized for doing so, but obesity experts and health ethicists claim the proposal might open the door for penalties associated with other individual choices that might result in increased medical costs.⁸⁵ These experts and ethicists also question whether the penalty proposal will achieve the desired results of reducing costs and improving individual health.⁸⁶

80. Janet Adamy, *Arizona Proposes Medicaid Fat Fee*, WALL ST. J., Apr. 1, 2011, at A3; Mark Carlson, *Arizona Medicaid Considers Tax On Smokers, Obese*, ABC NEWS (Apr. 1, 2011), <http://abcnews.go.com/Health/wireStory?id=13276359>; Ben Forer, *Arizona Governor Proposes Revamping Medicaid Program*, ABC NEWS (Apr. 1, 2011), <http://abcnews.go.com/Health/arizona-gov-jan-brewer-proposes-medicare-fat-fine/story?id=13274368>. Medicaid beneficiaries with chronic illnesses who fail to follow health plans designed by their physicians will also be subject to the \$50 penalty fee. Forer, *supra*.

81. Carlson, *supra* note 80.

82. Forer, *supra* note 80; see Timothy Williams, *Under an Arizona Plan, Smokers and the Obese Would Pay Medicaid Fee*, N.Y. TIMES, May 31, 2011, at A16.

83. Forer, *supra* note 80.

84. *Id.* Sinema's comments may have been directed only at individuals with diabetes who might also be subject to the penalty fee.

85. *Id.*

86. *Id.*

3. *Programs in Corporate America*

According to a 2010 Hewitt Associates survey, nearly half of large scale employers have aligned their thinking with Arizona and are not far behind Alabama.⁸⁷ Specifically, 47% (up from only 7% in 2009, representing a substantial increase in percentage) of the large employers surveyed said that by 2015, they intend to target fatness by imposing financial penalties on employees who fail to participate in health improvement programs or offering financial incentives for those who maintain “healthy”⁸⁸ weights.⁸⁹ The most popular form of penalty is a higher premium payment, favored by 81% of employers surveyed.⁹⁰ Nearly 20% of the employers have already implemented, or plan to implement, penalties in the form of higher deductibles and other out-of-pocket health expenses.⁹¹ A Fidelity Investments survey released in early 2011 noted a sharp uptick in employer use of incentives, rather than penalties, to encourage weight loss.⁹² Such incentives are designed to increase employee participation and are believed to have greater rates of long-term success.⁹³

Some well-known large employers have already implemented these incentive-type programs. American Express, for example, offers \$100 to employees for participating in a health survey and free health screening checks, which efforts have led to employee weight loss.⁹⁴ Whole Foods took a slightly different approach, offering voluntary health screenings to its employees and fatter in-store purchase discounts to thinner employees.⁹⁵ All Whole Foods employees receive a 20% store discount, but the Team Member Healthy Discount Incentive Program offers an “opportunity” for employees to “increase” that dis-

87. HEWITT ASSOCIATES, *THE ROAD AHEAD: UNDER CONSTRUCTION WITH INCREASING TOLLS* 11, 13–18 (2010), http://www.aon.com/attachments/thought-leadership/Hewitt_Survey_Findings_TheRoadAhead_2010.pdf; see *Hewitt Survey Shows Growing Interest Among U.S. Employers to Penalize Workers for Unhealthy Behaviors*, ENHANCED ONLINE NEWS (Mar. 17, 2010) [hereinafter EON], <http://eon.businesswire.com/news/eon/20100317005918/en>.

88. See *infra* note 105 and accompanying text.

89. HEWITT ASSOCIATES, *supra* note 87, at 18; EON, *supra* note 87.

90. HEWITT ASSOCIATES, *supra* note 87, at 18.

91. *Id.*

92. *Annual Wellness Study Finds Significant Jump in Incentive Dollars as Employers Report Improved Employee Participation*, FIDELITY.COM (Feb. 8, 2011) [hereinafter *Annual Wellness Study*], <http://www.fidelity.com/inside-fidelity/employer-services/2011-wellness-survey>; Katherine Hobson, *Employers Increased Wellness Incentives Last Year*, HEALTH BLOG (Feb. 8, 2011, 12:41 PM), <http://blogs.wsj.com/health/2011/02/08/employers-increased-wellness-incentives-last-year>.

93. *Annual Wellness Study*, *supra* note 92; Hobson, *supra* note 92.

94. Rabin, *supra* note 62.

95. Edgar Sandoval & Kathleen Lucadamo, *Whole Foods to give greater employee discounts to workers with lower BMI, cholesterol*, DAILY NEWS (Jan. 26, 2010), http://articles.nydailynews.com/2010-01-26/entertainment/29436953_1_discounts-free-health-screenings-chelsea-store.

count to as much as 30%.⁹⁶ Specifically, employees who participate in the screening are assigned to one of four categories—bronze, silver, gold, or platinum—based in large part on their BMI.⁹⁷ Employees must meet certain BMI benchmarks to reach any of the discount categories: for bronze, BMI must be less than 30; for silver, less than 28; for gold, less than 26; and for platinum, BMI must be less than 24.⁹⁸ Notably, the upper range of the “normal” weight category defined by the CDC is BMI 24.9,⁹⁹ nearly a full point on the scale above the platinum limit set by Whole Foods. John Mackey, the Whole Foods CEO, touted the Program as a new way of providing “incentives to encourage our Team Members to be healthier and to lower our health-care costs. We believe this is a win-win program that will help both our Team Members and our shareholders.”¹⁰⁰ Mackey’s concern, and the goal of the Whole Foods Program, notably focuses on reducing corporate healthcare costs and “help[ing]” shareholders retain higher profits.

Critics of the Whole Foods Program, including the National Association to Advance Fat Acceptance (NAAFA) and several consumers, call the Program “discrimination” and believe it is nothing more than a judgment based on appearance.¹⁰¹ In particular, the use of BMI as a health indicator drew criticism from experts in the field, including Dr. Kevin Volpp, director of the Center for Health Incentives at the University of Pennsylvania, and Joseph Newhouse, an economist at Harvard Medical School in the department of health care policy.¹⁰² These experts stated a few overarching concerns about the use of BMI in the incentive program: (1) distinctions between the BMI ranges listed for each of the discount categories are too small to have a significant impact on overall health; (2) the discounts only incentivize change for people who find it easy to lose weight; (3) BMI is a tool used to measure populations, not individuals, and can be misleading when

96. Letter from John Mackey, Chief Exec. Officer, Whole Foods, Inc., to all Whole Foods employees (Jan. 2010) [hereinafter Mackey Letter], http://cache.gawker.com/assets/images/39/2010/01/healthy_discount_letter_01.jpg.

97. *Attention Team Members!*, WHOLE FOODS MKT., http://cache.gawker.com/assets/images/39/2010/01/healthy_discount_poster_01.jpg (last visited Oct. 26, 2010).

98. *Id.*

99. *About BMI for Adults*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html (last visited Oct. 26, 2011).

100. Mackey Letter, *supra* note 96.

101. Sandoval & Lucadamo, *supra* note 95.

102. Joseph Brownstein, *Is Whole Foods' Get Healthy Plan Fair?*, ABC NEWS (Jan. 28, 2010), http://abcnews.go.com/Health/w_DietAndFitnessNews/foods-incentives-make-employees-healthier/story?id=9680047&page=1.

applied on an individual level; and (4) BMI is not necessarily a good indicator of overall health.¹⁰³

III. FACTS OF FATNESS

Not only do health insurance fat taxes detract from the communitarian health care model, but they do so based on an imperfect classification system. The scientific community disagrees about what results from fatness, what initially creates fatness, and how to measure fatness effectively. This Part provides critiques of the BMI scale used to designate who pays health insurance fat taxes, as well as the medicalized construction of fatness itself as a disease. Further, this Part assesses the utility of emphasizing science as justification for health insurance fat tax regimes.

A. Weighing the Body Mass Index

BMI may still reign in the U.S. as a measure of weight and health, but as Dr. Volpp and Mr. Newhouse indicated, this scale is not above critique or skepticism.¹⁰⁴ The Centers for Disease Control (CDC) tout BMI as the method of identifying a “healthy” weight,¹⁰⁵ but the initial

103. *Id.*; see Dominic Lawson, *Don't believe obesity figures—they're spun for a reason*, INDEP., Aug. 29, 2008, at 26, available at <http://www.independent.co.uk/opinion/commentators/dominic-lawson/dominic-lawson-dont-believe-obesity-figures-ndash-theyre-spun-for-a-purpose-912216.html>. Lawson stated the following:

More pertinently for us all, there is nothing wrong, or even unhealthy, in being obese, at least as defined by the official measurement known as the Body Mass Index. . . . [O]n current BMI definitions George Clooney and Russell Crowe are clinically ‘obese’ while Brad Pitt and Mel Gibson are ‘overweight.’ Meanwhile another doctor friend of mine points out that many of his anorexic patients would be classified as very healthy according to most conventional measurements, such as blood pressure; but clearly their attitude to food is anything but healthy.

Lawson, *supra*.

104. Brownstein, *supra* note 102.

105. *Assessing Your Weight*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/healthyweight/assessing/index.html> (last visited Oct. 26, 2011). Specifically, the CDC website states as follows:

BMI is a reliable indicator of body fatness. It is calculated based on your height and weight.

“Underweight”, “normal”, “overweight”, and “obese” are all labels for ranges of weight. Obese and overweight describe ranges of weight that are greater than what is considered healthy for a given height, while underweight is lower than what is considered healthy. If your BMI falls outside of the “normal” or Healthy Weight range, you may want to talk to your doctor or health care provider about how you might achieve a healthier body weight. Obesity and overweight have been shown to increase the likelihood of certain diseases and other health problems.

Id.

origin of BMI had nothing to do with health.¹⁰⁶ Further, the lines of demarcation between the various weight categories identified through BMI have not been fixed over time.¹⁰⁷ Similarly, the specific BMI number that arguably indicates whether a person is at greater risk for disease varies depending on the particular disease at issue.¹⁰⁸ In addition, BMI fails to account for the locus of fat within the body or the ratio of fat to muscle mass.¹⁰⁹ Each of these critiques should, at least in theory, chip away at the veracity and ultimate utility of BMI.

Perhaps surprisingly, what is known today as BMI can be traced back to an early nineteenth century survey of the physical characteristics of army recruits, which survey had absolutely nothing to do with health status.¹¹⁰ A Belgian astronomer, Adolphe Quetelet, sought to investigate the applicability of mathematical laws of probability to human beings, relying on body measurements of certain members of the French and Scottish armies.¹¹¹ Quetelet plotted his data points and generated a bell curve of weights relative to height, from which he identified the center of curve as the range of "normal" weight.¹¹² He also noticed that the normal weight range centered on the height measurement squared.¹¹³ With these calculations in hand, Quetelet theorized that people whose weights did not conform to this measurement of normalcy were more likely to be criminals or other troublemakers that required institutionalization, monitoring, or some other form of social control.¹¹⁴ In sum, fatness equaled deviance.¹¹⁵ Notably, though, that deviance was Quetelet's theoretical construction, not a health status indicator.¹¹⁶

In fact, body mass was a rather poor social classification tool, particularly because so many people in the nineteenth century struggled

106. OLIVER, *supra* note 1, at 16–18.

107. *Id.* at 22; NAT'L INSTS. OF HEALTH, CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS 1 (1998) [hereinafter CLINICAL GUIDELINES], http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf.

108. OLIVER, *supra* note 1, at 26.

109. *See About BMI for Adults, supra* note 99.

110. OLIVER, *supra* note 1, at 16–17.

111. *Id.*

112. *Id.* at 17.

113. *Id.*

114. *Id.* at 17–18.

115. *Id.* at 17.

116. Socially constructed deviance based on physiological characteristics continued into the twentieth century, creating what some call the "golden era of classification." *Id.* at 18. Under the guise of science, researchers measured skulls, body proportions, and other such physical features to segregate society into a caste system of sorts that, of course, consistently set the white aristocratic elite as the height of normalcy and everyone else as lowlife delinquents and criminals. *See id.*

to find sufficient food and nutrition.¹¹⁷ Fatness was a sign of wealth; people wanted to be fat to establish their membership in the social elite.¹¹⁸ Later in the nineteenth and early in the twentieth centuries, food became less scarce, so fatness lost its prestige and thin became chic.¹¹⁹ Medicine then shifted its opinion from supporting plumpness to advocating for weight loss.¹²⁰ Shortly thereafter, in the mid-1940s, the life insurance industry also supported this new trend, and Metropolitan Life Insurance (Met Life) developed standardized tables that correlated weight and mortality, modeled, in part, on Quetelet's bell curve.¹²¹ Today's BMI¹²² grew out of these Met Life tables, which used weight as an indicator of early mortality largely because it was easily measured, not because any causality had been established between fat and death.¹²³

Indeed, a notable distinction exists between predicting the likelihood of death based on BMI, which was the goal for Met Life, and establishing causality between increased BMI and increased mortality rates. Experts from the CDC looking at the same time period and similar data sets flatly disagreed about the link between fatness and mortality. An article published in the *Journal of the American Medical Association (JAMA)* claimed that in 2000, fatness caused at least 400,000 deaths.¹²⁴ The researchers stated that of all the causes of death analyzed in their report, this was "[t]he most striking finding."¹²⁵ Less than a year later, JAMA printed a correction notice stating that "there were multiple errors in reported data," which errors included a reduction in the number of deaths caused by fatness from 400,000 to 365,000.¹²⁶ Just a few months after the correction, a different set of CDC experts reported that only 111,909 excess deaths in

117. OLIVER, *supra* note 1, at 18; Laura Fraser, *The Inner Corset: A Brief History of Fat in the United States*, in *THE FAT STUDIES READER*, *supra* note 1, 11–12.

118. Fraser, *supra* note 117, at 12.

119. See, e.g., *id.* at 12–13.

120. *Id.* at 13.

121. OLIVER, *supra* note 1, at 19. Louis Dublin, a Met Life statistician, charted the death rates of Met Life's policyholders according to a height-weight ratio. *Id.*

122. The Centers for Disease Control (CDC) website states that BMI has four weight ranges: "underweight" (BMI is less than 18.5), "normal" (BMI is 18.5 to 24.9), "overweight" (BMI is 25.0 to 29.9), and "obese" (BMI is 30.0 or higher). *Assessing Your Weight*, *supra* note 105. A fifth range (or perhaps a subset of "obese") known as "morbidly obese" (BMI is 40.0 or higher) is used to classify the largest members of American society. See, e.g., OLIVER, *supra* note 1, at 55–56.

123. OLIVER, *supra* note 1, at 19.

124. Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 J. AM. MED. ASS'N 1238, 1238–40 (2004).

125. *Id.*

126. *Actual Causes of Death in the United States, 2000—Correction*, 293 J. AM. MED. ASS'N 298 (2005).

2000 were linked to obesity.¹²⁷ Further, individuals falling into the “overweight” category (BMI 25–29.9) had lower mortality rates than those in the “normal” category (BMI 18–24.9).¹²⁸ It appears all that can be concluded from this is that the relationship between body fat, health, and death is more complicated than the medical community might currently understand.¹²⁹

Similarly, although several studies have attempted to show that a plethora of diseases (including diabetes, hypertension, coronary artery disease, stroke, gallbladder disease, osteoarthritis, and certain types of cancers) are associated with fatness,¹³⁰ these studies can be viewed as methodologically deficient.¹³¹ Nearly all of these studies consist of population surveys rather than results of controlled experiments.¹³² Also, many do not take into account other possible health factors that might influence disease susceptibility and development.¹³³ Most notably, no single point on the BMI scale can be identified as the point at which the risk for diseases increases in a statistically significant way.¹³⁴ Public health officials, over time, have even disagreed on the numeric distinctions between the BMI categories.¹³⁵ In 1998, to match BMI classifications maintained by the World Health Organization, the CDC, NIH, and other U.S. public health officials lowered the upper threshold for the “normal” category to 25, down from 27.8 for men and 27.3 for women.¹³⁶ In essence, with this decrease, over 37 million Americans became fat overnight, even though their weights remained constant.¹³⁷ If BMI was such a powerful weight measurement and health indicator tool, it seems such a basic thing as the scaled numeric indicators of fatness should be discernable through medical evidence and analysis; instead, the changes have been based on politicking and no particular BMI point has been identified as the marker of increased health risk.¹³⁸

A 2008 analysis from *The Journal of Clinical Epidemiology* demonstrated that BMI is the poorest indicator of cardiovascular health, and that waist measurement is a better method of evaluating health condi-

127. Flegal et al., *supra* note 24, at 1863. See *supra* note 105 for a description of the various BMI categories.

128. Flegal et al., *supra* note 24, at 1863–64.

129. See OLIVER, *supra* note 1, at 34.

130. *Id.* at 25–27.

131. *Id.*

132. *Id.* at 26.

133. *Id.* at 27.

134. *Id.* at 26.

135. *Id.* at 22; CLINICAL GUIDELINES, *supra* note 107, at 1.

136. OLIVER, *supra* note 1, at 22.

137. *Id.* at 22.

138. See *id.* at 22–29.

tions and risks for hypertension, diabetes, and high cholesterol.¹³⁹ According to a similar study from Harvard Medical School, even women falling into the “normal” weight category using BMI are twice as likely to die early from heart disease or cancer if their waists are too large.¹⁴⁰ Simply stated, a person’s waist measurement should be less than half of that person’s height.¹⁴¹

When Japan began managing fat, it adopted the waist measurement strategy.¹⁴² At least as early as 2005, the Japanese health obsession was metabolic syndrome—*metaborikku shindoromu*, or “metabo” for short.¹⁴³ Metabo is essentially the existence of a set of factors that, in combination with each other, increase the risk of heart attack, stroke, diabetes, dementia, and even incontinence.¹⁴⁴ Japanese individuals are diagnosed with metabo if their waist measurement exceeds nationally prescribed limits (33.5 inches for men and 35.4 inches for women) and they have at least two of the other four risk factors: high blood pressure, high blood glucose, high cholesterol, and smoking.¹⁴⁵

In April 2008, the Japanese government implemented the “Metabo Law” expressly setting maximum waist measurements for all of its citizens aged forty to seventy-four.¹⁴⁶ Anyone who exceeds the limits may be forced to receive dieting guidance and “re-education” about nutrition and healthy weights.¹⁴⁷ Companies and local governments are responsible not only for conducting the measurement evaluations, but also for achieving a 10% reduction in their overweight populations by 2012 and a 25% reduction by 2015, and failure to achieve these targets will result in financial penalties.¹⁴⁸

139. See Tara Parker-Pope, *WAIST: Watch Your Girth*, N.Y. TIMES (May 13, 2008), <http://query.nytimes.com/gst/fullpage.html?res=9A0DE7D7153CF930A25756C0A96E9C8B63>.

140. *Id.*

141. *Id.*

142. Rebecca Palmer, *Western Ways Hit Japanese Waists*, DOMINION POST (Wellington, New Zealand), Dec. 27, 2008, at 17.

143. *Id.*

144. See David Nakamura, *In Japan, the Fat Police Patrol for Overweight Workers*, STAR-LEDGER, Nov. 28, 2009, at 2; Palmer, *supra* note 142; Parker-Pope, *supra* note 139.

145. Norimitsu Onishi, *Japan, Seeking Trim Waists, Decides to Measure Millions*, N.Y. TIMES (June 13, 2008), <http://www.nytimes.com/2008/06/13/world/asia/13fat.html?pagewanted=all>; Palmer, *supra* note 142; see also Ann Endo, *To Your Health—Jigsaw puzzle diagnosis: The pieces that fit metabolic syndrome*, DAILY YOMIURI (Tokyo), Aug. 19, 2007, at 23 (describing how Japan follows the International Diabetes Federation standard for diagnosing metabo, juxtaposed against the standard set by the U.S. National Cholesterol Education Program, with the latter being touted as the “most widely accepted” set of criteria).

146. Onishi, *supra* note 145; Palmer, *supra* note 142.

147. Lawson, *supra* note 103; Onishi, *supra* note 145.

148. Onishi, *supra* note 145; Palmer, *supra* note 142.

The Japanese government hails the Metabo Law as a method to rein in rapidly expanding health care costs in a country where most citizens are covered through public health care or their employers.¹⁴⁹ Critics of the Metabo Law, however, claim that the measurement maximums are too strict, likely resulting in numerous missed targets and thus serving as a thinly veiled method of shifting health care costs off the government and onto private employers.¹⁵⁰ For example, Japan's largest producer of personal computers estimates that it could incur up to \$19 million in penalty fees for failing to achieve its Metabo Law targets.¹⁵¹ Critics also state that the Japanese are thin enough and should not lose weight, that a bigger problem not addressed by the Metabo Law is that of underweight young girls, and that smoking (another risk factor) should be the Law's focus instead of fatness.¹⁵² Further, critics disparage the waist measurement system as "crude" due to inconsistent measurement standards; one study shows that doctors' measurements for the same patient's waist can vary as much as three inches.¹⁵³

Critics aside, the middle-aged Japanese population must now contend with the Metabo Law. Some rush to comply, buying exercise equipment and popping herbal fat remedy pills in an attempt to avoid the shame associated with fatness, the label as "an unacceptable burden" on national health care costs, and the perceived lack of respect for, and responsibility to, Japanese society.¹⁵⁴ Others, however, simply ignore it, claiming that their waistlines are none of the government's business.¹⁵⁵ Perhaps the dissidents have the best approach; the media identified at least one woman who went on a crash diet, eating only vegetable soup, and exercised daily for three weeks before her measurement, only to revert to eating pasta and drinking beer once she came in under the limit.¹⁵⁶ That hardly seems like an effective or healthy weight management system. More importantly, the Metabo Law misses the point—while there may be some correlation between fatness and overall health, correlation does not equal causation between fat and poor health, and the scientific community still debates the latter.¹⁵⁷

149. Onishi, *supra* note 145.

150. *Id.*

151. *Id.*

152. Nakamura, *supra* note 144; Onishi, *supra* note 145.

153. Nakamura, *supra* note 144.

154. *Id.*; Tom Plate, *Heavyweight Approach to the Obesity Problem*, SOUTH CHINA MORNING POST, Jun. 25, 2008, at 17.

155. Onishi, *supra* note 145.

156. Nakamura, *supra* note 144.

157. See *supra* notes 117–41 and accompanying text (concerning what fatness "causes"); see also *infra* section III.B (concerning what "causes" fatness).

B. Fatness Medicalized and Vilified

Ask a physician or public health official about fat and the answer probably centers on disease. Pose the same question to someone not directly related to the health, drug, or diet industries and the answer probably centers on laziness and lack of self-control. Both views contain some truth,¹⁵⁸ but neither fully describes the nature of fatness, and neither escapes systemic social negativity.

Fatness became a disease through decades of efforts by geneticists, physicians, the pharmaceutical industry, the diet industry, public health officials, academic researchers, bariatric surgeons, and others who stood to benefit from that medicalization.¹⁵⁹ A host of financial opportunities present themselves when fatness is viewed as a condition that can be treated or cured with a pill or a program. Diet products and programs gained much popularity in the middle of the twentieth century, particularly among women, with the help of physicians who prescribed diuretics, amphetamines, and other weight loss drugs to both children and adults.¹⁶⁰ Notably, that uptick in diet products coincided chronologically with the publication of the Met Life Table.¹⁶¹

By 1970, 70% of American households used “low-cal” products.¹⁶² That same year, Weight Watchers’ profits rose to \$8 million.¹⁶³ Diet fads continued to grow through the 1970s and 1980s, which time frame also saw the advent of plastic surgery.¹⁶⁴ The 1990s brought hospital diet centers and “miracle diet pills” like Fen-Phen and Redux, which boosted diet industry profits in 1996 to more than \$30 billion.¹⁶⁵ Approximately 18 million people took Fen-Phen in 1996, as prescribed by their doctors.¹⁶⁶ By 2004, Americans spent \$46 billion

158. See, e.g., Kathleen LeBesco, *Quest for a Cause: The Fat Gene, The Gay Gene, and the New Eugenics*, in THE FAT STUDIES READER, *supra* note 1, at 65, 70–72.

159. OLIVER, *supra* note 1, at 6, 29–35, 37–58, 101–15; Lyons, *supra* note 1, at 76–85.

160. Jerome P. Kassirer & Marcia Angell, *Losing Weight—An Ill-Fated New Year’s Resolution*, 338 NEW ENG. J. MED. 52, 52 (1998); Lyons, *supra* note 1, at 76.

161. See OLIVER, *supra* note 1, at 70; *supra* notes 121–123 and accompanying text.

162. Lyons, *supra* note 1, at 76.

163. *Id.*

164. OLIVER, *supra* note 1, at 71–72.

165. Lyons, *supra* note 1, at 76–78.

166. Kassirer & Angell, *supra* note 160, at 53. The next year, both Fen-Phen and Redux were recalled because of potentially fatal side effects such as primary pulmonary hypertension and cardiovascular disease. *Id.* at 52; Lyons, *supra* note 1, at 76–78. These two drugs are not the only diet products with serious negative side effects. More recently, the FDA approved alli for over-the-counter sales as a weight loss aid, even though it can lead to “bowel movement changes . . . [that] may include oily spotting, loose stools, and more frequent stools that may be hard to control.” *Alli Faqs*, ALLI, <http://www.myalli.com/faq.aspx> (click on “safety and drug interactions” and then click on “is alli safe?”; click on “treatment effects” and then click on “does alli have any side effects?”) (last visited Oct. 26, 2011). In other words, people might become thinner by taking alli, but they also might

on diet products and programs, exclusive of bariatric and other weight loss surgeries.¹⁶⁷ All of that spending depended directly on a conception of fatness as a disease that could be cured or remedied with the appropriate medical intervention.

Public health officials, influenced by diet and health industry lobbyists, followed a similar pattern of promoting obesity as a disease, and eventually a disease of epidemic proportion.¹⁶⁸ In 1985, the National Institute of Health Consensus Conference on Obesity declared “obesity” to be a “killer disease” in order to obtain insurance coverage for the raging diet fads and treatments just described.¹⁶⁹ In 1994, former U.S. Surgeon General C. Everett Koop declared a “great crusade” against fat when he launched the *Shape Up America!* campaign,¹⁷⁰ which campaign was funded by Jenny Craig, Weight Watchers, Slim-Fast, and other diet industry giants to the tune of up to \$1 million each.¹⁷¹ Shortly thereafter, in 1997, William Dietz left his post at Tufts University School of Medicine for a new position with the CDC as a director of the Division for Nutrition and Physical Activity, and the next year, he and a CDC colleague created the beginnings of a PowerPoint presentation showing how the obesity disease had become an epidemic.¹⁷² The presentation took hundreds of spreadsheet cells indicating obesity trends from 1985–1999 and reduced that data to a series of color-coded maps of the nation showing, by an increase in the number of red “obese” states (where obesity was defined as a BMI of 30 or more), how much the obesity infection had grown.¹⁷³ While no red states existed in 1985, twenty red states appeared on the 1999 map.¹⁷⁴ Of course, some of these states are deceptively large, geographically, when the real measure is population—consider, for example, North Dakota.¹⁷⁵ Nonetheless, when asked about the impact of the presentation, Dr. Dietz said that “[t]hese maps have shifted the

have to carry a spare pair of pants, just in case. For a discussion of diet drugs that may cause similar side effects, such as bowel leakage and diarrhea, as well as depression, anxiety, and heart problems, see OLIVER, *supra* note 1, at 52.

167. Lyons, *supra* note 1, at 77. Notably, bariatric surgery provides another example of how the medicalization of fatness promotes the padding of certain pockets. For a discussion of bariatric surgery and the profits made by this industry niche, see OLIVER, *supra* note 1, at 53–56.

168. Lyons, *supra* note 1, at 79.

169. *Id.*

170. Dr. C. Everett Koop Launches A New “Crusade” To Combat Obesity in America, SHAPE UP AMERICA! (Dec. 6, 1994), http://www.shapeup.org/about/arch_pr/120694.php; see also Kassirer & Angell, *supra* note 160 at 53 (discussing the reasons for the “medical campaign against obesity”).

171. SOLOVAY, *supra* note 11, at 151, 213–14; Lyons, *supra* note 1, at 79; Solovay & Rothblum, *Introduction*, in THE FAT STUDIES READER, *supra* note 1, at 1.

172. OLIVER, *supra* note 1, at 39–40.

173. *Id.* at 40–41.

174. *Id.*

175. *Id.* at 42–43.

discussion from whether a problem exists to what we should do about the epidemic.”¹⁷⁶ Further, “[n]othing has been more effective at increasing the visibility of the obesity epidemic than the CDC slides.”¹⁷⁷ Before accepting his position at the CDC, Dr. Dietz was a paid consultant to Hoffman-La Roche and Knoll Pharmaceuticals—two companies developing diet drugs.¹⁷⁸ He left Tufts for the CDC because he believed obesity needed to be addressed nationwide, which he thought he could not accomplish from academia.¹⁷⁹

Though Dietz sought a broader audience through a more public venue, academic researchers also profit from the medicalization of fatness, and thus promote this view to secure grant funding, publish articles, and become tenured.¹⁸⁰ Academics first discovered the “fat gene” in mice in 1995.¹⁸¹ More research and studies, however, produced evidence that the mouse fat gene did not occur in sufficiently large proportion among fat humans, so it could not truly account for the obesity epidemic.¹⁸² That one fat gene became, through more research efforts, over seventy different gene sets that might determine fatness.¹⁸³ “While the media often reports discovery of a ‘fat’ gene, this is far from the case—what they should report is the discovery of one of many possible fat genes.”¹⁸⁴ The more fat genes science discovers, the more research is needed to explain the genetic codes and try to find a “cure” to correct the fat “abnormality.”¹⁸⁵ The results of that research can be extremely valuable to the pharmaceutical companies that stand to generate large profits from the latest and greatest weight loss pill.¹⁸⁶

Perhaps this medicalization should not come as a surprise given the tendency to medicalize behaviors that do not carry social approval.¹⁸⁷ But, the science that medicalizes also vilifies. Anti-fat bias permeates the medical profession.¹⁸⁸ Numerous studies show physicians, mental health professionals, and nurses see fat patients as weak, ugly, awkward, and unworthy of respect.¹⁸⁹ One study con-

176. *Id.* at 42.

177. *Id.* at 43; see Lyons, *supra* note 1, at 80.

178. Lyons, *supra* note 1, at 79–80.

179. OLIVER, *supra* note 1, at 39.

180. *Id.* at 45.

181. LeBesco, *supra* note 158, at 69.

182. *Id.*

183. OLIVER, *supra* note 1, at 105.

184. *Id.*

185. See generally, LeBesco, *supra* note 158.

186. See OLIVER, *supra* note 1, at 111–14.

187. Kassirer & Angell, *supra* note 160, at 53; see also OLIVER, *supra* note 1, at 43–44 (“Today, it seems that any physical inconvenience, symptom, or correlate of a health problem has been elevated to the status of a disease.”).

188. SOLOVAY, *supra* note 11, at 218–26.

189. *Id.* at 218–19.

ducted by Tufts University found nurses do not want to even touch fat patients, let alone provide care.¹⁹⁰ Many fat people, particularly women, avoid seeking medical treatment because of the bias and apathy for fatness that the medical profession projects.¹⁹¹ This avoidance holds true even when the underlying condition is serious, such as cervical cancer, and the treatment is intended to address that underlying condition.¹⁹² “Disrespectful and different healthcare treatment, the result of unchecked bias, creates a legacy of frustration and despair that completely alienates fat people from the medical care system. . . . Every participant in [a] survey [of fat patients] had avoided a needed medical visit, particularly in relation to gynecological care.”¹⁹³ Ironically, this alienation comes from a body of professionals who, at least in theory, are the ones to whom fat people should turn if they want to change their weight and should understand that fatness is not a creation of complete autonomy and choice, but rather is a combination of nature and nurture.¹⁹⁴

Indeed, no one truly knows what causes fatness.¹⁹⁵ What is known, however, is that “the simple calories-in, calories-out equation does not really explain why some people are heavy and some people are thin because it assumes that both factors are under our immediate control.”¹⁹⁶ Professor Deborah Rhode provides a useful perspective:

Although about two-thirds of surveyed Americans believe that people are fat because they lack self-control, experts generally agree that weight is not simply a matter of willpower. Weight reflects a complex interaction of physiological, psychological, socioeconomic, and cultural factors. Genetically determined set-points work to keep bodies within a predetermined range; furthermore, when dieters reduce their caloric intake and increase their exercise, their metabolism slows down to compensate and makes any weight loss difficult to sustain. The problems are compounded by sedentary occupations and ‘toxic environments’ that lack recreational opportunities and encourage unhealthy food choices.¹⁹⁷

Despite these complexities, fat people are systematically blamed for their fatness because society generally maintains that fatness is a person’s individual responsibility.¹⁹⁸ Likewise, “fat people are blamed for their health problems,”¹⁹⁹ such as diabetes, coronary artery disease, and hypertension, even though medical science disagrees on the actual causal connection between fatness, on the one hand, and mor-

190. *Id.* at 219.

191. *Id.* at 218–23.

192. *Id.* at 218.

193. *Id.* at 222–23.

194. OLIVER, *supra* note 1, at 100–21.

195. *Id.*

196. *Id.* at 101.

197. Rhode, *supra* note 2, at 1050.

198. OLIVER, *supra* note 1, at 100.

199. Deb Burgard, *What Is “Health at Every Size?”* in THE FAT STUDIES READER, *supra* note 1, at 42.

tality and disease, on the other.²⁰⁰ The systemic blame and stigma are pervasive, real, and serious; society believes that fat people are lazy, undisciplined, unfit, dishonest, sloppy, ugly, socially unattractive, less productive, lacking in self-control, dirty, stupid, and worthless.²⁰¹ These stereotypes are ingrained so deeply that fat individuals face disparate treatment in schools, in employment, in health care delivery, and in the civil and criminal justice systems.²⁰² People, and particularly women, value thinness so highly that over the past several decades, they have tried a variety of diet pills and programs that in some cases resulted in body mutilation, serious disease, and even death.²⁰³ People did this even though nearly all diets (up to 95%) simply do not work.²⁰⁴ “[D]iscrimination based on [fatness] unfairly stigmatizes individuals based on factors that often are at least partly beyond their control. That stigma imposes substantial financial and psychological costs, [and] undermines individuals’ self-esteem”²⁰⁵ In short, America hates fat, fears becoming fat, and systemically devalues or wholly rejects the members of society whose size challenges the normative vision of the thin body.²⁰⁶

C. Misleading Reliance on Science

As demonstrated above, members of the scientific community have yet to agree on what causes fatness, what fatness causes, or even how to effectively measure fatness (and, arguably, how to define it, given the shifting BMI markers).²⁰⁷ Employers nonetheless base their health insurance fat taxes on the “science” of fatness.²⁰⁸ BMI is used to identify people who must pay the penalty, relying on the science indicating that fatness causes disease and/or death (thus increasing expected health care usage and, accordingly, insurance coverage premiums).²⁰⁹ Similarly, exceptions to the penalties are based on actual

200. OLIVER, *supra* note 1, at 22–28.

201. Jane Korn, *Too Fat*, 17 VA. J. SOC. POL’Y & L. 209, 222, 226 (2010); Rhode, *supra* note 2, at 1051.

202. SOLOVAY, *supra* note 11, at 16–17 (health care, education), 47–63 (education), 86–98 (bias in jury selection), 99–121 (employment), 218–32 (health care and involuntary commitment of fat people); Korn, *supra* note 201, at 224–29 (employment and health care); Rhode, *supra* note 2, at 1049 (education).

203. See, e.g., Lyons, *supra* note 1, at 75–77.

204. *Id.* at 75; see Glenn Gaesser, *Is “Permanent Weight Loss” an Oxymoron?*, in THE FAT STUDIES READER, *supra* note 1, at 37, 38–39.

205. Rhode, *supra* note 2, at 1051 (footnotes omitted); see also Harriet Brown, *For Obese People, Prejudice in Plain Sight*, N.Y. TIMES, Mar. 16, 2010, at D6, available at <http://www.nytimes.com/2010/03/16/health/16essa.html> (discussing overt prejudices against fat people).

206. See OLIVER, *supra* note 1, at 60–78.

207. See *supra* sections III.A–III.B.

208. See *supra* section II.B.

209. See *supra* notes 124–141 and accompanying text.

or attempted weight loss or a physician's note, relying on the science indicating that fatness is caused by biology (in the latter case) or, conversely, the science indicating that fatness is caused by laziness and lack of self-control and personal responsibility (in the former case).²¹⁰ Facially, this scheme seems to cover the realm of possible scientific bases.

But the scientific reliance is misleading. Assume, for the moment, that science could prove fatness causes disease, premature death, and other health problems, thereby increasing utilization and costs of health care. The same can be said for severe thinness.²¹¹ However, thinness is not penalized by health insurance fat taxes. Now assume that in addition to establishing what fatness causes, science could also establish that fatness is caused by individual choice. People engage in activities, by choice, that increase their prospective use of health care; consider rock climbing, motorcycle driving, skydiving, bungee jumping, full contact martial arts, auto racing, hang gliding, and other thrill-seeking or extreme sports.²¹² All of these activities drive up life insurance costs, for example, but have no bearing on health insurance costs.²¹³ And yet, health insurance fat taxes penalize individuals for choosing to be fat (or choosing not to be thin) and driving up the prospective costs of health care. The reason for selecting fatness as a focus must not, therefore, rely on scientific support for expected health care expenditures. Instead, the reason must be anti-fat bias and stigma.²¹⁴

[T]he obese elicit blinding rage and disgust in our culture and are often viewed in terms that suggest an infant sucking hungrily, unconsciously at its mother's breast: greedy, self-absorbed, lazy, without self-control or willpower. People avoid sitting next to the obese (even when the space they take up is not intrusive); . . . socially, they are considered unacceptable at public functions (one man wrote to "Dear Abby," saying that he was planning to replace his brother and sister-in-law as honor attendants at his wedding, because "they are both quite overweight"). Significantly, the part of the obese anatomy most often targeted for vicious attack, and most despised by the obese themselves, is the stomach, symbol of consumption²¹⁵

210. See *supra* section III.B.

211. See RHODE, *supra* note 3, at 41; Flegal et al., *supra* note 24.

212. See, e.g., Emmet Pierce, *Thrills that freak out insurers*, MSN MONEY, <http://money.msn.com/insurance/thrills-that-freak-out-insurers> (last visited Jan. 22, 2012). Arguably, even driving could be added to the list. See Zack McMillin, *The most dangerous activity: driving*, SEATTLE TIMES (Jan. 5, 2010), http://seattle.times.nwsourc.com/html/living/2010708175_driving05.html (stating that driving an automobile is the leading cause of long-term disability, and the leading cause of deaths among Americans ages one to thirty-four).

213. See Pierce, *supra* note 212.

214. See, e.g., SUSAN BORDO, UNBEARABLE WEIGHT: FEMINISM, WESTERN CULTURE, AND THE BODY 202 (2003); RHODE, *supra* note 3 *passim*.

215. BORDO, *supra* note 214, at 202 (citation omitted) (referencing MARCIA MILLMAN, SUCH A PRETTY FACE: BEING FAT IN AMERICA (1980)).

Health insurance fat taxes represent a systemic backlash against this “vicious . . . consumption,” disguised as a method of promoting wellness,²¹⁶ irrespective of medical science.

IV. SYSTEMIC IMPLICATIONS OF HEALTH INSURANCE FAT TAXES: FAT COVERING

As described in Part III, fatness is not necessarily as purely bad as commonly believed, nor do health science professionals know the distinct medical consequences of fatness. Moreover, science has yet to determine what causes fatness. Nonetheless, fatness carries a heavy social weight—a burden beyond the pounds displayed on the bathroom scale.²¹⁷ That burden manifests in several contexts. One such context, health insurance fat taxes, forces fat individuals to cover their fatness by making their body sizes easier for mainstream thinness to overlook. An examination of social constructions of fatness and queerness assists the explication of fat covering.

“[F]at is the new gay.”²¹⁸ Despite the slogan’s flaws,²¹⁹ the sentiment contains certain truths concerning social treatments of fatness and queerness.²²⁰ Scholarship and activism about queerness and fat-

216. See *infra* section V.B.

217. See, e.g., *supra* notes 214-215 and accompanying text.

218. Jann Arden, *Twitter Post*, TWITTER (Apr. 26, 2011), <http://twitter.com/jannarden>.

219. For commentary on the utility of the similar slogan, “black is the new gay,” see Katrina C. Rose, *Where the Rubber Left the Road: The Use and Misuse of History in the Quest for the Federal Employment Non-discrimination Act*, 18 TEMP. POL. & CIV. RTS. L. REV. 397, 456 n.312 (2009); Craig J. Konnoth, Note, *Created in its Image: The Race Analogy, Gay Identity, and Gay Litigation in the 1950s–1970s*, 119 YALE L.J. 316 (2009); Keith Boykin, *Is Gay the new Black?*, THE DAILY VOICE (Dec. 18, 2008), <http://thedailyvoice.com/voice/2008/12/is-gay-the-new-black-001418.php> (“Black people still aren’t equal and neither are gays. It doesn’t help the gay rights cause to exaggerate the success of the black struggle or to diminish the success of the LGBT movement.”); LZ Granderson, *Commentary: Gay is not the new black*, CNN POLITICS (July 16, 2009), <http://edition.cnn.com/2009/POLITICS/07/16/granderson.obama.gays/index.html>; Michael J. Gross, *Gay Is the New Black?*, ADVOCATE, http://www.advocate.com/News/Daily_News/2008/11/16/Gay_is_the_New_Black_ (last updated July 23, 2009) (“[Gay] oppression, by and large, is nowhere near as extreme as blacks’, and [gays] insult [blacks] when [gays] make facile comparisons between our plights.”); Clarence Page, *Gay pride, black prejudice*, CHI. TRIB. (Dec. 7, 2008), http://articles.chicagotribune.com/2008-12-07/news/0812060439_1_gay-marriage-gay-rights-gay-activists (“How about, ‘Gay is the new gray?’ The gray area for a lot of black Americans like me is not in the issue of gay rights but in the comparison some gay activists make between that issue and the movement for racial equality.”); Monique Ruffin, *It’s Official: Gay Is the New Black*, HUFF. POST (Dec. 28, 2011), http://www.huffingtonpost.com/monique-ruffin/gay-civil-rights_b_1168897.html.

220. As a point of fact, studies have shown that lesbians have higher rates of BMIs in the “overweight” and “obese” categories as compared to straight women. Bianca D. M. Wilson, *Widening the Dialogue to Narrow the Gap in Health Disparities*, in THE FAT STUDIES READER, *supra* note 1, at 54, 55. One expert observes that these

ness represent what Judith Butler has termed “morphological politics”—collective nonconformist constructions of the body, its functionalities, its capacities, and its appearances—that challenge dominant normative visions.²²¹ Certain critical tools that have developed in these academic and political discourses, exploring queerness and fatness as loci of contestation of body norms, are instructive in understanding the operation of those norms and the maintenance of relevant socially constructed binary schemes.²²²

First, both queerness and fatness have been constructed on socially normative binaries. With regard to the gender binary, consider the transgender community. Trans people push normative conceptions of “male” and “female.”²²³ Professor Dean Spade notes that although this binary is mandated and inscribed in several contexts, the distinctiveness of these categories is a legal fiction, and this fiction is particularly problematic for trans people.²²⁴ Further, although typical government identity forms require people to check either the “M” or “F” box, it is not clear that this distinction actually serves an important function or that government systems have reached a consensus about the proof required to establish one or the other.²²⁵ In short, as Professor Spade posits, government classification systems ubiquitously and invisibly influence and reconfirm the socially constructed, and falsely polarized, gender binary.²²⁶ Moreover, the classification systems infuse the binary with moral choices and shape the realities of people whose lives must be described by the classification catego-

studies carry a “fat-is-bad” overtone that transcends fatness to homosexuality. *Id.* While that anti-fat bias perhaps does not fully permeate into lesbian social systems, the American fat-thin dichotomy is pervasive and smaller social systems cannot fully shield against the mainstream. *See id.* at 60; cf. Rhode, *supra* note 2, at 1057 (discussing how “[s]exualized grooming standards also penalize gays and lesbians who reject conventional gender norms” as seen in the case of a high school senior who, as a lesbian who typically wore clothing similar to her male classmates, refused to abide by her school’s rule that all girls wear scoop-neck dresses for their yearbook photographs).

221. EXAMINED LIFE: EXCURSIONS WITH CONTEMPORARY THINKERS 200 (Astra Taylor ed., 2009); accord Kathryn Abrams, *Performing Interdependence: Judith Butler and Sunaura Taylor in The Examined Life*, 21 COLUM. J. GENDER & L. 474, 483–84 (2011).

222. *See, e.g.*, BORDO, *supra* note 214; FEMINIST AND QUEER LEGAL THEORY: INTIMATE ENCOUNTERS, UNCOMFORTABLE CONVERSATIONS (Martha A. Fineman et al. eds., 2009); SUSIE ORBACH, *FAT IS A FEMINIST ISSUE* (1997); Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731 (2008).

223. Spade, *supra* note 222, at 746.

224. *Id.*

225. *See id.* (“These classification problems reveal the limits of the assumptions about gender that underlie systems of government data collection and identification. These assumptions, in turn, match cultural assumptions about gender that most people understand as non-controversial, obvious, or natural.”).

226. *Id.* at 744–47 (citing GEOFFREY C. BOWKER & SUSAN LEIGH STAR, *SORTING THINGS OUT: CLASSIFICATION AND ITS CONSEQUENCES* (1999)).

ries.²²⁷ The “rules related to government gender classification do not simply discover and describe maleness and femaleness, but instead *produce* two populations marked with maleness and femaleness as effects and objects of governance.”²²⁸

Similarly, health insurance fat taxes (re)create two populations marked with fatness and thinness as objects of employers’ decision-making, which decision-making process is influenced by economic incentives and anti-fat bias. Thinness is deemed acceptable, regardless of how a person came to be thin, while fatness is punished. Fear permeates this fat-thin dichotomy, evidenced by widespread fear of becoming fat even among thin people (manifested in part by eating disorders).²²⁹ That fear is fueled by the omnipresent negativity associated with fatness, leaving fat people with no option but to condemn their own bodies. This point is not meant to diminish the flaws in the creation and perpetuation of both the gender and the body size binaries. It is important to question why a label as one or the other must be ascribed at all, particularly when both of these classifications function so fluidly in people’s lived experiences.

Second, because of their respective academic and political challenges to normative visions of the body, both queerness and fatness have been subjected to scientific efforts to “cure” these “diseases.”²³⁰ In the mid-1990s, the media exploded with news of both a gay gene and a fat gene;²³¹ the impetus for such scientific research and excitement about the discoveries must be probed. While scientific causes of fatness and queerness might serve as bases for advocacy under existing legal regimes,²³² “science and medicine have long been instrumental in oppressing fat and queer people, providing argument after argument that pathologize the homosexual or ‘obese’ individual [P]lacing bodies under the microscope of science, in the name of liberal projects of self-improvement, in fact reinscribes their deviance and increases their oppression.”²³³

227. *Id.* at 744–46.

228. *Id.* at 747.

229. See BORDO, *supra* note 214, at 140–41.

230. See LeBesco, *supra* note 158, at 65; Yoshino, *supra* note 12, at 784–86.

231. LeBesco, *supra* note 158, at 68.

232. *Id.* at 70; see also SOLOVAY, *supra* note 11, at 128–64 (discussing disability law as it applies to obesity); Jane Byeff Korn, *Fat*, 77 B.U. L. Rev. 25 (1997) (discussing fat discrimination and whether obesity should be considered an impairment); Korn, *supra* note 201, at 234 (dismissing employment discrimination complaint because the court found that employer’s decision not to promote plaintiff was based on appearance, not a belief that plaintiff had a medical disorder); Dylan Vade & Sondra Solovay, *No Apology: Shared Struggles in Fat and Transgender Law*, in THE FAT STUDIES READER, *supra* note 1, at 167, 168–74 (discussing fat and transgender law).

233. LeBesco, *supra* note 158, at 70; see also SOLOVAY, *supra* note 11, at 131 (discussing whether labeling obesity as a disability is helpful).

Kathleen LeBesco argues the real reason underlying these scientific efforts to identify genetic causes for fatness and queerness was to eradicate both from society—a modern-day “new consumer eugenics movement aimed at abolishing aberrations seemed socially or aesthetically undesirable (but far from life threatening).”²³⁴ This theory is not hard to accept, given the diseased historical construction of homosexuality²³⁵ and the hopes and dreams, even today, for a pill to cure fatness.²³⁶

Third, in the absence of effective curative methods, both fatness and queerness have faced socially constructed fears of contagion. Envisioning fatness as an epidemic indicates its viral nature, spreading through the country like an infection.²³⁷ Merely associating with fat individuals can ascribe fat stigma to thin people,²³⁸ and according to an article in the *New England Journal of Medicine*, thin people are more likely to become fat by spending time with fat friends.²³⁹ Apparently, fatness is contagious.²⁴⁰ Similarly, after gay advocates finally succeeded in deleting homosexuality from psychiatric diagnostic materials, the “contagion model” of queerness emerged, positing that straight people could be infected with homosexuality through interactions with queer people.²⁴¹ These contagion models likely arose out of fear of the socially deviant end result—queerness or fatness.²⁴²

Fourth, both identities have been (and in some cases, still are) labeled as mutable, grounded in a rhetoric of choice.²⁴³ Society resists accepting that queerness and fatness might be products of both nature

234. LeBesco, *supra* note 158, at 65.

235. See Yoshino, *supra* note 12, at 784–803.

236. See OLIVER, *supra* note 1, at 112–13.

237. See *supra* notes 169–179 and accompanying text.

238. Korn, *supra* note 201, at 222.

239. Nicholas A. Christakis & James H. Fowler, *The Spread of Obesity in a Large Social Network over 32 Years*, 357 NEW ENG. J. MED. 370, 371, 377–78 (2007).

240. See, e.g., Adam R. Pulver, Note, *An Imperfect Fit: Obesity, Public Health, and Disability Antidiscrimination Law*, 41 COLUM. J.L. & SOC. PROBS. 365, 387, 406–08 (2008); Gina Kolata, *Find Yourself Packing It On? Blame Friends*, N.Y. TIMES, July 26, 2007, at A1, available at <http://www.nytimes.com/2007/07/26/health/26fat.html?pagewanted=all>; Sally Squires, *A Question From the Edge: Is Fat Contagious?*, WASH. POST, Aug. 3, 2004, at F1, available at <http://www.washingtonpost.com/wp-dyn/articles/A35302-2004Aug2.html> (describing a scientific search for a “fat virus”).

241. Yoshino, *supra* note 12, at 801–02 (citing Paul Cameron & Kirk Cameron, *Do Homosexual Teachers Pose a Risk to Pupils?*, 130 J. PSYCHOL. 603, 611–13 (1996)).

242. *Id.* at 802 (“[T]he fundamental fear about homosexuality is the apocalyptic ‘fear of a queer planet,’[] the fear that homosexuality can spread without being spread thin. [Further,] [b]ecause it so closely tracks popular fears, the contagion model has proved an extremely effective anti-gay rhetorical device.”).

243. See, e.g., SOLOVAY, *supra* note 11, at 190–95 (fatness); M. Neil Browne et al., *Obesity as a Protected Category: The Complexity of Personal Responsibility for Physical Attributes*, 14 MICH. ST. U. J. MED. & L. 1, 9–10, 39–47 (2010) (fatness);

and nurture, perhaps due to the normative value of binary schemes.²⁴⁴ Moreover, the search for or labeling of any cause of queerness or fatness (biology or choice) perpetuates the new eugenics project paradigm.²⁴⁵

Fifth, in various ways, society demands that both queerness and fatness assimilate into the dominant paradigms of straightness and thinness. Using homosexuality as an illustrative example, Professor Yoshino delineates three types of assimilation—converting, passing, and covering—that have been systematically imposed.²⁴⁶ At first, society tried to eradicate homosexuality by converting gays into straights through the use of hysterectomy, clitoridectomy, vasectomy, castration, lobotomy, electroshock therapy, hormone treatments, aversion therapy, and psychoanalysis.²⁴⁷ Converting precludes and prohibits the existence of queerness. Accordingly, Professor Yoshino posits that conversion casts a moral judgment on its object; it is “not a value-neutral event, but one that transforms the damned into the saved; and not a reversible event, but in theory a unique occurrence.”²⁴⁸ Professor Yoshino continues:

[C]onversion differs profoundly from either passing or covering. Passing and covering are both perceived to be compromise formations in which the underlying identity is ostensibly preserved, modified only for popular consumption. In contrast, conversion is thought to be a more complete embrace or surrender. It is believed to change not only the expression of an identity, but the underlying substance of it.²⁴⁹

Passing, one of the “compromise” methods, allows for queer people to exist but not in the public eye.²⁵⁰ Essentially, the passing norm represents the aspects of society that keep a queer person in the closet.²⁵¹ Passing is an assumed possibility for all queer people; if they wanted to dress straight, act straight, and make up stories about straight sexual partners, they could probably do so.²⁵² The availability of passing does not, however, mean that homophobia ended or even

Janet Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503, 517–18 (1994) (queerness).

244. See sources cited *supra* note 243.

245. See *supra* notes 230–36 and accompanying text.

246. Yoshino, *supra* note 12, at 772; see *supra* notes 12–17 and accompanying text.

247. Yoshino, *supra* note 12, at 784–89; see also *id.* at 790–803 (providing a history of gay conversion).

248. *Id.* at 786.

249. *Id.*

250. *Id.* at 786, 811–27. Yoshino notes that passing and converting may conflate and should not be viewed as necessarily or consistently distinct; the same action might be considered passing and converting depending on the knowledge of the audience. *Id.* at 826–27. Likewise, queerness might not exist, in a way, if it is not seen by society. *Id.*

251. *Id.* at 811–27.

252. *Id.* at 824–25.

decreased in severity.²⁵³ The distinction in rhetoric might have only preserved the underlying animus.²⁵⁴ As Professor Yoshino explains, legal schemes such as the military's "don't ask, don't tell" policy evidenced this preservation in at least some contexts.²⁵⁵

Covering—the other “compromise” that emerged around the turn of the millennium—allows for queer individuals to acknowledge their sexuality both publicly and privately, but concurrently mandates that sexual orientation be downplayed.²⁵⁶ In other words, queerness can be acknowledged, but it cannot be flaunted.²⁵⁷ Professor Yoshino identifies gay marriage as a current example of covering, juxtaposed against open relationships.²⁵⁸ These types of covering issues cause conflict within the queer rights movement between those who seek to establish and maintain similarities with straights (those who adopt covering and, in this example, support the legalization of gay marriage) and those who embrace differences from straights (those who resist covering and, in this example, reject the institution of marriage).²⁵⁹

Applying Professor Yoshino's theoretical model²⁶⁰ to fatness, it becomes apparent that health insurance fat taxes mandate covering.

253. *Id.* at 825 (citing Reva B. Siegel, “*The Rule of Love*”: *Wife Beating as Prerogative and Privacy*, 105 YALE L.J. 2117 (1996) (articulating the “preservation-through-transformation” concept)).

254. *Id.*

255. *Id.* at 827–31.

256. *Id.* at 838. As with passing and converting, the same action might be both passing and covering simultaneously, depending on the audience. For example, a lesbian mother acting straight around all of her children's friends is covering for her children, but passing to the friends because the friends are unaware of her sexual orientation. *Id.* at 772–73, 836–38.

257. *Id.* at 772–73, 838–42.

258. *Id.* at 776–77, 847–49.

259. *Id.* at 839–49. Yoshino calls these two groups “normals” and “queers,” respectively:

By normals, I mean a group of people who are openly gay, but who seek to cover their sexual orientations, emphasizing their commonality with straights. . . . By ‘queers,’ I mean a group of people who do not seek to cover their orientations, choosing instead to embrace their difference from the mainstream.

Id. at 839. Further, “normals seek to change gays to accommodate the mainstream, while ‘queers’ seek to change the mainstream to accommodate gays. The main tool of normals in this fight is covering Conversely, the main tool of ‘queers’ is the refusal to cover” *Id.* at 842. This Article does not adopt Yoshino's terminology because of its use of the terms “queer” and “queerness” elsewhere, but the concepts are nonetheless conveyed herein.

260. *See id.* at 773, 778–79, 868–75 (describing the “weak performative model” that does not trivialize covering, as compared to passing or converting, and allows space for the intersection of, and fluidity between, nature and nurture vis-à-vis the cause of queerness). In passing, Professor Yoshino states that obesity cannot find protection under his weak performative model. *Id.* at 933. This Article challenges that conclusion. *See infra*, Part V.

Total assimilation through conversion might be the conceptual goal for fat people,²⁶¹ given the systemic pressures to annihilate fat by losing weight and staying thin, but health insurance fat taxes do not necessitate such a result.²⁶² The Alabama Program described above does not evaluate or track numbers of pounds dropped by fat employees enrolled in weight loss programs. Plus, conversion is a relative impossibility, in light of the extremely high failure rates of dieting.²⁶³

Similarly, passing is not possible. Passing involves hiding the underlying identity component.²⁶⁴ How could a fat person hide the fat, other than by staying home? Once a fat person walks outside and greets the world, fatness is in plain sight. The public eye might choose to look away, essentially rendering fat individuals invisible despite the amount of space they occupy.²⁶⁵ That resultant invisibility, however, does not negate actual presence. Fat people exist, undeniably.²⁶⁶ As one scholar observes, “[o]besity, unlike some other stigmatized conditions such as alcoholism or drug addiction, is apparent to all and impossible to hide.”²⁶⁷ Society cannot force fat people to pass because they cannot hide their bodies from view.

Covering, the only remaining option, accurately describes the effects of health insurance fat taxes on fat people. Simply put, this regime forces fat people whose BMIs are too high (where the line of demarcation is wholly within the purview of employers’ discretion) to either take steps to remedy the problem by losing weight, regardless of whether weight is ever lost, or to conclusively state, with confirmation from a physician, that some biological factor prevents weight loss. The first option requires an admission that fat individuals should always strive to change their bodies and convert to thinness, even if that goal is never reached. The second option requires an admission of defeat by fatness, such that victims are created where perhaps no victims actually exist. Although plenty of people can and do lead happy,

261. See Yoshino, *supra* note 12, at 771 (presenting the view that assimilation cures all social evils and thus all people should strive to assimilate). An argument could be made that the few individuals who do lose weight and keep it off have converted, but as discussed herein, such a result is not required.

262. See *supra*, section II.B.

263. See, e.g., Lyons, *supra* note 1, at 75–77.

264. See Yoshino, *supra* note 11, at 811–27.

265. See, e.g., W. CHARISSE GOODMAN, *THE INVISIBLE WOMAN: CONFRONTING WEIGHT PREJUDICE IN AMERICA* x, 1–17 (1995).

266. It would be difficult to argue to the contrary, given the media coverage and other discourse surrounding the “obesity epidemic” and rising rates of fatness. Cf. Yoshino, *supra* note 12, at 840–41 (analyzing the “we’re here, we’re queer, get used to it” slogan).

267. Korn, *supra* note 201, at 221.

healthy lives with fatness,²⁶⁸ this admission of victimization reinforces a systemic vision of fatness that attempts to preclude such lives from existing. Both types of admissions make fatness easier for society to overlook because fat individuals implicitly and intrinsically accept (even if under duress) the systemic rhetoric of, and commonplace adherence to, anti-fat bias and beliefs that fatness is bad and unhealthy.²⁶⁹ Just as society does, through the regime of health insurance fat taxes, fat people invisibly state that their bodies are flawed, and, through extension, that their selves are immoral, weak, and worthless. This is the essence of systemically mandated covering.²⁷⁰

Further, the effects of covering within the queer rights movement align with current trends in the fat rights movement. Professor Yoshino states that covering divides queer activists who embrace covering and those who reject it.²⁷¹ Similarly, some fat rights activists could be seen as embracing covering while others flatly reject it. For example, Marilyn Wann believes America needs a fat revolution, embracing the Health at Every Size model²⁷² and the belief that fat people can enjoy good health and long life, while vehemently combating, among other things, the position that fat people should lose weight and the vision of fatness as a disease.²⁷³ Implementing a different approach, the Yale Rudd Center for Food Policy & Obesity, founded by Kelly Brownell, operates under a mission statement that incorporates, as its main goals, “to improve the world’s diet, prevent obesity, and reduce weight stigma.”²⁷⁴ According to Wann, the Rudd Center embraces covering while she expressly opposes it.²⁷⁵ Without judging the value of either approach, health insurance fat taxes brings the conflict between the two into the foreground, and might inhibit the work of fat activists who reject covering.

268. See, e.g., Heather McAllister, *Embodying Fat Liberation*, in *THE FAT STUDIES READER*, *supra* note 1, at 305; see also SOLOVAY, *supra* note 11, at 233–38 (detailing the acceptance of fatness and the efforts against fat discrimination).

269. See *supra* notes 218–22 and accompanying text.

270. See generally Yoshino, *supra* note 11, at 772–73, 838–42.

271. See *supra* notes 258–59 and accompanying text.

272. See Burgard, *supra* note 199, at 42; Lyons, *supra* note 1, at 83–85; see also Wilson, *supra* note 220, at 61 (advocating an approach that balances health and cultural beliefs of beauty and encourages appropriate physical activity and good nutrition).

273. Marilyn Wann, *Foreword* to *THE FAT STUDIES READER*, *supra* note 1, at ix. Marilyn Wann is the author of *FAT!SO?: BECAUSE YOU DON’T HAVE TO APOLOGIZE FOR YOUR SIZE!* (1998) and the creator of “Yay! Scales,” which scales display compliments instead of pounds. She has also performed with a fat synchronized swimming team and other fat visual arts groups. See *About the Contributors*, in *THE FAT STUDIES READER*, *supra* note 1, at 351, 356–57.

274. *FAQs*, YALE RUDD CENTER FOR FOOD POL’Y & OBESITY, http://www.yaleruddcenter.org/who_we_are.aspx?id=18 (last visited Oct. 26, 2011).

275. See Wann, *supra* note 273, at xvii.

Other similarities between queer covering and fat covering again demonstrate the extent of alignment between the two identities. For example, queer people who cover by being “discreet” or “private” about their sexuality get to keep their jobs and their children, while “open and notorious” or “flagrant” queerness revokes those privileges.²⁷⁶ The same is true for fat individuals who reject fatness and embrace covering (providing for them to keep their children and employment) and, conversely, individuals who embrace fatness and reject covering (revoking those privileges).²⁷⁷ Covering demonstrates how “assimilation can be an *effect* of discrimination as well as an *evasion* of it.”²⁷⁸

V. FAT RIGHTS, HEALTHY BODIES, AND EXISTING LEGAL REGIMES

Although the health insurance fat tax regime facially distinguishes between fat and thin, thus creating covering-type discrimination, the regime is legal nationwide. It is true that certain jurisdictions prohibit weight-based discrimination.²⁷⁹ However, health insurance fat taxes are part of employee benefits programs sponsored by employers and thus, the Employee Retirement Income Security Act²⁸⁰ (ERISA) governs their administration.²⁸¹ ERISA itself contains no antidiscrimination provision; rather, other federal antidiscrimination laws provide this type of protection for employees concerning covered benefit plans.²⁸² Consistent with the Congressional intent to fill the field

276. Yoshino, *supra* note 12, at 850.

277. See SOLOVAY, *supra* note 11, at 64–77 (“If the Child is Fat, Is the Parent Unfit?”), 99–121 (discussing weight-based employment discrimination); see also *id.* at 13–24 (noting that mother was charged with child abuse for not preventing daughter’s obesity).

278. Yoshino, *supra* note 12, at 772.

279. One such jurisdiction is the state of Michigan. The Elliott-Larsen Civil Rights Act states that “[t]he opportunity to obtain employment, housing and other real estate, and the full and equal utilization of public accommodations, public service, and educational facilities without discrimination because of . . . weight . . . as prohibited by this act, is recognized and declared to be a civil right.” MICH. COMP. LAWS § 37.2102(1) (2010). For an overview of this state law and certain local ordinances that prohibit discrimination on the basis of appearance, see Rhode, *supra* note 2, at 1081–90. Notably, in 2007–2008, Massachusetts considered a bill that would have added weight to its anti-discrimination statute as well. See Mary Carmichael, *Do We Really Need A Law To Protect Fat Workers?*, BOSTON GLOBE MAG., Aug. 5, 2007, at 26; Laurel J. Sweet, *TALL ORDER: Bill Would Target Bias Based on Weight & Height*, BOSTON HERALD, Mar. 24, 2008, at A3. The bill was defeated. See MASS. GEN. LAWS ch. 151B, § 4 (2011) (prohibiting employment discrimination based only on “race, color, religious creed, national origin, sex, sexual orientation, . . . genetic information, or ancestry,” not weight or height).

280. 29 U.S.C. §§ 1001–1461 (2006).

281. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90–91 (1983).

282. *Id.* at 104–05 (describing relevant legislative history).

of law about these plans, ERISA preempts any state antidiscrimination law that provides protection above the floors set by federal antidiscrimination laws, such as Title VII and the ADA.²⁸³ Accordingly, the only possible laws that might be used to invalidate health insurance fat taxes are those two federal statutes, and neither provides that result.²⁸⁴ Furthermore, ACA provisions about wellness programs can be viewed as bolstering the legality of health insurance fat taxes.²⁸⁵ This set of conclusions and observations creates yet another question, specifically, why antidiscrimination law, systemically, fails to operate in a way that consistently combats differential treatment of individuals whose bodies exhibit non-normative physical characteristics. The last section of this Part attempts to answer that inquiry.

A. Title VII and the ADA

Title VII prohibits discrimination in employment practices based on “race, color, religion, sex, or national origin.”²⁸⁶ The statute does not prohibit weight-based rules of employment that apply neutrally across these identities. If, however, a facially neutral rule has a disparate impact on minority employees, based on one of these identities, then the rule violates Title VII.²⁸⁷ Because of higher rates of fatness among minority races and women, coupled with the legal normative construction of a healthy body as white and male, attempts have been made to invalidate weight rules in employment based on a disparate impact argument.²⁸⁸ While a few of these cases have been successful²⁸⁹ because of a “sex-plus” or race element,²⁹⁰ fatness alone is not

283. *Id.* at 102–06 (holding that state antidiscrimination laws consistent with Title VII are saved from ERISA preemption, but any part of those state laws prohibiting conduct that would be legal under the federal regime is preempted); *Tompkins v. United Healthcare of New England, Inc.*, 203 F.3d 90, 96–97 (1st Cir. 2000) (extending the partial preemption holding of *Shaw* to state antidiscrimination laws concerning disabilities, as compared to the provisions of the ADA).

284. It is not the intent here to provide a detailed explication of weight discrimination cases and analyses under these statutes. Such work has been done elsewhere. *See, e.g.*, Browne et al., *supra* note 243, at 10–27; Korn, *supra* note 232, at 40–50. For purposes of this Article, it is sufficient to state that current antidiscrimination law generally does not protect fatness.

285. This Article assumes, *arguendo*, that the ACA is constitutional.

286. 42 U.S.C. § 2000e-2(a) (2006).

287. *See* 42 U.S.C. § 2000e-2(k) (delineating the burden of proof in disparate impact cases).

288. *See* SOLOVAY, *supra* note 11, at 111–18, 122–26; Rhode, *supra* note 2, at 1076–78.

289. *See, e.g.*, *Mieth v. Dothard*, 418 F. Supp. 1169 (M.D. Ala. 1976) (invalidating state prison system height and weight requirements for the position of correctional counselors because of disparate impact on women, relying on statistical evidence of such disparate impact), *aff'd in part, rev'd in part*, *Dothard v. Rawlinson*, 433 U.S. 321 (1977).

290. *See* Rhode, *supra* note 2, at 1076–77.

protected under Title VII.²⁹¹ Thus, a Title VII challenge would probably fail, and even if it was successful, fat white men might be excluded from decisional protection.

Similarly, the ADA²⁹² does not protect all fatness from discrimination.²⁹³ The ADA prohibits discrimination in employment, public services, and public accommodations on the basis of a disability, whether real or perceived.²⁹⁴ Under the statute, a “disability” is defined as “a physical or mental impairment that substantially limits one or more major life activities” or “a record of such an impairment” or “being regarded as having such an impairment.”²⁹⁵ In rare circumstances, fatness may be considered an impairment, but such cases require morbidly obese plaintiffs,²⁹⁶ and even morbidly obese plaintiffs can lose in court, despite sufficient evidence of discriminatory treatment, because they cannot meet the definitional elements of “disability” as such elements have been interpreted by the courts.²⁹⁷ Accordingly, most fat plaintiffs lose their ADA cases,²⁹⁸ and it seems likely that an ADA-based challenge brought against health insurance fat taxes would similarly fail.

B. The ACA

Rather than prohibiting weight-based discrimination, the ACA might encourage it through its wellness plan participation incentives. The law contains two antidiscrimination provisions, neither of which is likely to apply to health insurance fat taxes. The first states that “[a] group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under

291. 42 U.S.C. § 2000e-2(a).

292. The ADA applies to private employers, see 42 U.S.C. § 12111(5) (2006), and section 504 of the Rehabilitation Act of 1973 applies the same anti-discrimination provisions to public employers and employers that receive federal funding, see 29 U.S.C. § 794(a), (d) (2006). The analyses of both statutes proceed in virtually identical fashions, and guidance for one can be used as guidance for the other. Thus, for purposes of the analysis herein, reference to the ADA should be understood to include both the ADA and section 504 of the Rehabilitation Act. See 29 U.S.C. § 794(d) (“The standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under [the ADA].”). Similarly, the analysis of *Cook v. Rhode Island*, 10 F.3d 17 (1st Cir. 1993), see *infra* notes 328–47 and accompanying text, applies to ADA interpretation and application as well.

293. SOLOVAY, *supra* note 11, at 146; Browne et al., *supra* note 243, at 22–23; Korn, *supra* note 232, at 28; Rhode, *supra* note 2, at 1078–80.

294. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213 (2006).

295. 42 U.S.C. § 12102(1).

296. See Korn, *supra* note 232, at 42–43, 51–52.

297. Rhode, *supra* note 2, at 1078–81; see *infra* note 339 and accompanying text.

298. Rhode, *supra* note 2, at 1078–81; Korn, *supra* note 201, at 232.

the terms of the plan or coverage based on any of the following health status-related factors”²⁹⁹ This provision shall be referred to herein as the “health status rule.” Weight is not expressly included in the list of factors, though it could fall under several of those enumerated, such as “health status,” “medical condition,” “medical history,” or possibly “genetic information,” depending on which experts provide consultation.³⁰⁰ Even assuming *arguendo* that weight is included, this provision likely will not apply to health insurance fat taxes because it pertains to plan/coverage eligibility, not to the amount paid for that coverage once enrolled. The second antidiscrimination provision states that “an individual shall not, on the ground[s] prohibited under title VI of the Civil Rights Act of 1964 . . . or section 504 of the Rehabilitation Act of 1973 . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any [federal] health program or activity.”³⁰¹ Likely, this provision also will not apply to health insurance fat taxes because weight is not protected under Title VI of the Civil Rights Act³⁰² or section 504 of the Rehabilitation Act.³⁰³ In addition, this second provision applies only to federal health programs, leaving private employers who do not receive federal funds beyond the scope of the rule.

Since neither of the antidiscrimination provisions applies, complete focus is turned to the wellness program provisions. Generally, under the ACA, a wellness program is “offered by an employer” and “designed to promote health or prevent disease.”³⁰⁴ The health status rule notwithstanding, participation in wellness programs may generate premium discounts, rebates, or other rewards based on health status factors, provided certain other programmatic conditions are satisfied.³⁰⁵

299. ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 156 (2010) (to be codified at 42 U.S.C. § 300gg-4) (creating new Public Health Service Act § 2705(a) [hereinafter PHSA]).

300. *Id.* (creating new PHSA § 2705(a)(1)–(9)). The vagueness of these enumerated factors may be alleviated in the future by regulations promulgated by the Secretary of Health and Human Services. Other sections of the ACA indicate that health status includes weight. *See* § 4201(c)(3)–(4) (to be codified at 42 U.S.C. 300u-13) (requiring community-based prevention health plans to “promote healthier lifestyles” and “conduct activities to measure changes in the prevalence of chronic disease risk factors among community members” such as “changes in weight”); § 4206 (identifying “weight” as a wellness plan health risk factor).

301. § 1557(a) (to be codified at 42 U.S.C. § 18116).

302. 42 U.S.C. § 2000d (2006) (listing race, color, and national origin as the only three protected identities).

303. *See supra* notes 292–98 and accompanying text.

304. ACA § 1201 (creating new PHSA § 2705(j)(1)(A)).

305. *Id.* (referring to new PHSA §§ 2705(j)(1)(B), 2705(j)(1)(C), 2705(j)(3)). If “all similarly situated individuals” are eligible for the same reward, then a wellness program does not base any conditions for obtaining the rebate or reward on health status factors and thus does not violate the health status rule. *Id.* Such pro-

The primary condition concerns the financial value of the reward. Specifically, health status distinctions are permissible if the wellness program participation reward does not exceed 30% of the original cost of coverage under the applicable health plan.³⁰⁶ Notably, “cost of coverage” includes both employee and employer contributions to the cost of health care,³⁰⁷ so the reward may be significantly larger than 30% of just the employee’s contribution. For example, if the total health insurance cost per month is \$500 and the employee’s contribution is \$150, the reward may carry a value equal to the entire employee contribution (representing 30% of the total cost), rather than only \$45 (representing 30% of the employee contribution amount). The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward value to up to 50% of the cost of coverage if they “determine that such an increase is appropriate.”³⁰⁸ Rewards may include discounts or rebates of premium payments, partial or full waivers of cost-sharing responsibilities (such as deductibles, copayments, and coinsurance), waiver of surcharges for services, or coverage for an additional service that would not otherwise be covered under the health plan.³⁰⁹

Several additional conditions apply to wellness program rewards that differentiate on the basis of health status.³¹⁰ First, the program must have “a reasonable chance of improving the health of, or preventing disease in, participating individuals.”³¹¹ It may not be “overly burdensome, . . . a subterfuge for discriminating based on a health status factor, . . . [or] highly suspect in the method chosen to promote

grams include reimbursement for fitness center memberships, diagnostic testing that does not require a specific outcome (e.g., a cholesterol level) in order to obtain the reward, and reimbursement for smoking cessation programs regardless of whether the individual actually quits. *Id.* (referring to new PHSA § 2705(j)(2)).

306. *Id.* (referring to new PHSA § 2705(j)(3)(A)).

307. *Id.*

308. *Id.*

309. *Id.*

310. *Id.* (referring to new PHSA § 2705(j)(3)(B)–(D)).

311. *Id.* (referring to new PHSA § 2705(j)(3)(B)). Other provisions in the ACA indicate that a programmatic goal of weight loss will satisfy the “improving health” condition. For example, the ACA offers “community transformation grants” for “prevention health activities” that are designed to “promote healthier lifestyles.” *Id.* § 4201(c)(3)(A). Many of the listed activities focus on health foods, nutrition, and physical activity. *Id.* § 4201(c)(2)(B). The success of these activities depends upon “measure[d] changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities” such as “changes in weight.” *Id.* § 4201(c)(4)(A)–(B). Similarly, “weight” is listed as a risk factor for pilot wellness programs based at community health centers that serve particularly at-risk populations. *Id.* § 4206 (referring to new PHSA § 330(s)(3)(B)(i)).

health or prevent disease.”³¹² Also, the reward must be “made available to all similarly situated individuals” at least once a year.³¹³ In order to satisfy this condition, an employer must maintain a “reasonable alternative standard” or waiver of the particular health status benchmark for individuals for whom it is “unreasonably difficult” or “medically inadvisable” to meet that benchmark.³¹⁴ So long as the wellness program reward system adopted by an employer satisfies these conditions, the reward system is legal under the ACA, regardless of whether it results in health status differentiation.

The Alabama Program exemplifies how ACA wellness programs justify differentiations based on fatness. Alabama state employees whose BMIs are 35 or higher must pay a \$25 monthly health insurance fat tax unless they participate in a weight loss program, actually lose weight, or provide a note from a physician indicating that a medical condition that precludes weight loss.³¹⁵ Because the state bills the program as a method of improving health and includes the doctor’s note as an alternative method of avoiding the fat tax, it satisfies the ACA conditions for a legal wellness program.³¹⁶

312. *Id.* § 1201 (referring to new PHSA § 2705(j)(3)(B)). Again, the vagueness of these terms and conditions might later be explained in regulations, but the statutory text provides only this.

313. *Id.* (referring to new PHSA § 2705(j)(3)(C)–(D)).

314. *Id.* (referring to new PHSA § 2705(j)(3)(D)(i)). Employers may seek confirmation from medical professionals that achieving the benchmark is unreasonably difficult or medically inadvisable. *Id.* (referring to new PHSA § 2705(j)(3)(C), (D)(ii)).

315. *See supra* notes 67–79 and accompanying text.

316. *See supra* notes 304–14 and accompanying text. Information about the total cost of health insurance coverage is unavailable on the SEIB website. The author assumes that the cost of coverage does not exceed the 30% maximum. Notably, in April 2009, North Carolina enacted a health insurance fat tax scheme for its state employees, similar to the Alabama Program. N.C. Sess. Laws 2009-16, § 2(b) (creating the “Comprehensive Wellness Initiative”). This Comprehensive Wellness Initiative was set to impose, among other things, a health insurance fat tax on July 1, 2011, for employees with BMI of 40 or more. *See* Jennifer Calhoun, *Obese state workers to bear greater health-care costs*, FAYETTEVILLE OBSERVER (Oct. 13, 2010), <http://www.fayobserver.com/articles/2010/10/13/1039063?sac=home>; Hal Herzog, *Fat people aren’t the enemy*, NEWSOBSERVER.COM (Feb. 4, 2010), <http://www.newsobserver.com/2010/02/04/318765/fat-people-arent-the-enemy.html>. Just a year later, in May 2010, the North Carolina House of Representatives filed a bill to repeal the health insurance fat tax. H.B. 1968, 2009 Gen. Assemb. (N.C. 2009) (entitled “An Act to Repeal the Body Mass Index (BMI) Penalty From the North Carolina State Health Plan for Teachers and State Employees”). Though the 2010 bill failed, in May 2011, the Comprehensive Wellness Initiative was repealed in its entirety. N.C. Sess. Laws 2011-85, § 1.5; 2011-96. Media coverage and relevant press releases fail to explain the reason for the repeal. *See, e.g.*, Press Release, The State Health Plan Prepares for Follow-up Enrollment (Jun. 10, 2011), http://www.shpnc.org/newsRoom/archives/2011/news_20110610.aspx. Perhaps the General Assembly recognized the flaws inherent to health insurance fat taxes, as described herein.

C. Collective Cover-up

The above analyses of federal laws demonstrate how the American legal system supports the perpetuation of anti-fat bias and the maintenance of potentially harmful, unrealistic body size norms. Only one state in the country protects against discrimination based on fatness.³¹⁷ That state-based fatness protection, however, effectively becomes nullified vis-à-vis health insurance fat taxes because of the nature of the legal system governing their administration.³¹⁸

As suggested earlier,³¹⁹ this gap in the system results from pervasive anti-fat bias and stigma. Fatness is the one remaining basis on which people can outwardly judge others without worry of repercussion.³²⁰ Cultural norms dictate that fat is bad, a disease that should be eradicated.³²¹ The country believes that its citizens can, and should, make their bodies conform to normative thinness. The current legal framework reflects this “assimilationist bias. It maintains that groups that can assimilate are less worthy of protection than groups that cannot. It further suggests that the only acceptable defense to a demand for assimilation is the inability to accede to it.”³²² Stated otherwise, and to use Professor Yoshino’s terminology, when individuals cannot convert or pass, they receive legal protection from discrimination based on the underlying identity, such as race, sex, or disability.³²³

However, fat individuals cannot pass or convert, and yet they still have no legal recourse for any repercussions based on their fatness.³²⁴ Particularly given the scientific evidence that fatness is not a pure choice, it seems that society, collectively, should recognize that even though fat hatred persists, probably it should not. Collectively, society should understand that fat people are not wholly to blame for their fatness, and yet society torments these individuals specifically because of their body size. American lawmakers should acknowledge given the available medical evidence, that some people are fat, just as some people are short, and some have blue eyes, and some are Black. Eye color, for example, is a relatively neutral characteristic;³²⁵ gener-

317. See *supra* note 279 and accompanying text.

318. See *supra* notes 279–83 and accompanying text (discussing ERISA preemption).

319. See *supra* notes 211–16 and accompanying text.

320. Indeed, Alabama and other employers have already implemented widespread programs that effectively do so. See, e.g., *supra* section II.B.

321. See *supra*, section III.B.

322. Yoshino, *supra* note 12, at 779.

323. *Id.*

324. See *supra* Part IV.

325. See Leslie Bender, *Genes, Parents, and Assisted Reproductive Technologies: Arts, Mistakes, Sex, Race, & Law*, 12 COLUM. J. GENDER & L. 1, 66 n.196 (2003); Mary Coombs, *Sexual Dis-Orientation: Transgendered People and Same-Sex Marriage*, 8 U.C.L.A. WOMEN’S L.J. 219, 238 (1998) (identifying eye color as “insignificant”);

ally, it does not form substantial parts of people's identities. Race, though, does form a person's identity, whether a person wants it to do so or not.³²⁶ Civil rights law emerged because of the negative consequences of that systemic impact. Nevertheless, systemic norms about fatness endure, and no federal law aims to curtail that practice.³²⁷

Health insurance fat taxes provide a method for society to perpetuate its anti-fat bias under the cover of promoting health. The goal seems good on its face; people want to be healthy. Looking one step deeper, however, as this Article has shown, health insurance fat taxes offer an opportunity to hide systemic anti-fat bias by forcing fat people to pay for their fatness, their moral failure, their bad bodies. In short, the health insurance fat taxes regime creates a vehicle for collective cover-up of anti-fat bias with the force of the law lending support.

An oft-cited successful weight disability case—*Cook v. State of Rhode Island, Department of Mental Health, Retardation, and Hospitals*³²⁸—illustrates how collective cover-up emerges in ADA³²⁹ analysis of fatness. Bonnie Cook was an attendant at a Rhode Island residential facility for mentally retarded persons.³³⁰ She had a "spotless work record" for the five years she worked there, and when she left, she did so voluntarily.³³¹ After two years, she reapplied for her

Charles R. Lawrence III, *The Id, The Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 330 (1987) (citing to the work of Richard Wasserstrom and stating that "race does not function in our culture as does eye color, which is an irrelevant category, an unimportant cultural fact"); Deborah Rhode, *Feminist Critical Theories*, 42 STAN. L. REV. 617, 637 (1990) (noting that eye color is "unimportant" and dismissing queries as to whether sex would ever become similarly unimportant); cf. Lawrence H. Tribe, *Lawrence v. Texas: The "Fundamental Right" That Dare Not Speak Its Name*, 117 HARV. L. REV. 1893, 1912 (2004) (identifying eye color as a "morally neutral characteristic" while sarcastically including race as a similarly neutral characteristic).

326. See Lawrence, *supra* note 325, at 637; see also Abrams, *supra* note 221, at 484 (identifying disability and gender dissidence as "socially-imposed identities").

327. One main distinction between race and gender discrimination, on the one hand, and fatness discrimination on the other, is the obviousness of that discrimination. Race has a blatant and facial, social, and legal history of discrimination. Dating back to the three-fifths law, through the era of slavery and well into the twentieth century with sanctioned segregation, racial discrimination existed, facially, in American law. See, e.g., Civil Rights Act of 1964, Pub. L. 88-352, 78 Stat. 101. The civil rights movement could focus efforts on combating that facial discrimination and rely thereon when combating more covert discriminatory impacts. Fatness, however, has no such discriminatory obviousness in its history. Indeed, the story of fatness described in Part II precludes such obviousness, since fatness was formerly a sign of wealth and high social status. Anti-fat discrimination has always existed beneath the legal surface. In this way, collective cover-up as described herein may apply to fatness, but might not apply to racism. Then again, perhaps affirmative action, retrospectively, was a form of collective cover-up.

328. 10 F.3d 17 (1st Cir. 1993).

329. See *supra* note 292 and accompanying text.

330. *Cook*, 10 F.3d at 20.

331. *Id.*

position only to be rejected strictly because of her weight, even though she passed the mandatory pre-employment physical.³³² She filed suit under section 504 of the Rehabilitation Act (RHA), based on a “perceived disability” theory, and after surviving a Rule 12(b)(6) motion to dismiss, the jury awarded her \$100,000 in compensatory damages.³³³ On appeal, the First Circuit held that morbid obesity qualified as a “covered impairment” under the RHA, whether actual or perceived.³³⁴ Specifically, the court held “the jury reasonably could have found that, though people afflicted with morbid obesity can treat the manifestations of metabolic dysfunction by fasting or perennial undereating, the physical impairment itself—a dysfunctional metabolism—is permanent.”³³⁵ Accordingly, the First Circuit upheld the jury’s award to Ms. Cook.³³⁶

This decision, though, perpetuates the same systemic vision of fatness that health insurance fat taxes also perpetuate, namely, that fatness is a bad personal choice deserving of punishment unless a medical, biological, essentially uncontrollable reason can be established. The result in *Cook* purports to offer protection from anti-fat discrimination, but that protection extends only to those individuals whose fatness rises to a level of morbid obesity and for which a medical cause can be established.³³⁷ In this way, the *Cook* decision shows how collective cover-up emerges through the law. It proffers fat rights, but only facially and only for a small and specific subclass of individuals, thereby covering up the lingering systemic anti-fat bias that still prohibits protection for most fat individuals.

Looking more closely at the details of the decision, collective cover-up emerges through the First Circuit’s discussions of mutability and voluntariness.³³⁸ Though both issues arose in the context of whether fatness constitutes an “impairment” under the law, the ultimate impact of mutability and voluntariness appears in the “substantially limiting” component of the disability analysis.³³⁹ First, the court stated

332. *Id.* at 20–21.

333. *Id.* at 21–22.

334. *Id.* at 22–23. To state a successful claim under the RHA against a federally funded program, a plaintiff must establish that: (1) she applied for a position within the program, (2) she had a “cognizable disability” at the time of application, (3) she was nonetheless qualified for the position, and (4) she was not hired solely because of the disability. *Id.*; see also *supra* notes 292–98 and accompanying text (discussing the likely failure of plaintiffs’ claims under the ADA, even if morbidly obese, and noting that the analysis under section 504 of the RHA is virtually identical to that applied to claims brought under the ADA).

335. *Id.* at 24.

336. *Id.* at 28.

337. *Id.* at 24.

338. *Id.* at 23–24.

339. See *supra* notes 294–95, 335 and accompanying text. A “disability” is defined as “a physical or mental impairment that substantially limits one or more major life

that the mutability of the plaintiff's condition is irrelevant to determining whether or not the condition constitutes an impairment.³⁴⁰

Mutability is nowhere mentioned in the state or regulations, and we see little reason to postulate it as an automatic disqualifier under section 504. It seems to us, instead, that mutability is relevant only in determining the substantiality of the limitation flowing from a given impairment. So viewed, mutability only precludes those conditions that an individual can easily and quickly reverse by behavioral alteration from coming within section 504.³⁴¹

What, then, happens to fat people who are perceived to be able to “easily and quickly” change their fatness? They fall outside the protection of the law. Similarly, under the “law of the case”³⁴² described above, morbid obesity resulting from metabolic dysfunction is a permanent condition justifying a finding of an impairment. Mutability might protect the morbidly obese from discrimination, but only if they can establish a medical reason for their fatness. Other individuals, who cannot show a malfunctioning metabolism, are still blamed for their

activities” or “a record of such an impairment” or “being regarded as having such an impairment.” 42 U.S.C. § 1201(1) (2006). In 2008, Congress passed certain amendments to the ADA. ADA Amendments Act of 2008, 42 U.S.C. §§ 12101–12213 [hereinafter ADAAA]. One such amendment, in response to the Supreme Court's decision in *Sutton v. United Airlines, Inc.*, 527 U.S. 471, 475 (1999), stated that “[t]he determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as . . . medication, medical supplies, equipment, or appliances, . . . prosthetics . . . , hearing aids . . . , mobility devices, . . . reasonable accommodations or auxiliary aids or services; or . . . learned behavioral or adaptive neurological modifications.” 42 U.S.C. § 12102(3)(4)(E)(i). At least one scholar has posited that this change in the law means that “[a]ny idea that a plaintiff who is obese would have to diet or have bariatric surgery has now been laid to rest.” Korn, *supra* note 201, at 242. This is a questionable result. Health insurance fat taxes require exactly that—diet or bariatric surgery or some other effort to lose weight. The difference between weight loss “mitigating measures” and, say, hearing aids or prosthetics is that the underlying condition associated with the latter group enumerated in the ADAAA is considered immutable. The aid may help an individual cope or otherwise live with the particular condition, but the condition remains. Fatness is still envisioned as wholly mutable, and within this construction, weight loss changes the underlying condition, alleviating the impairment. See also *infra* notes 341–46, 349–52 and accompanying text (discussing the First Circuit's analysis involving the mutability and voluntariness of the plaintiff's weight).

340. *Cook*, 10 F.3d at 23–24.

341. *Id.* at 23 n.7. This interpretation is set forth in dicta, arising out of the court's critique of the trial court's instruction to the jury that a “condition or disorder is not an impairment unless it . . . constitutes an immutable condition that the person affected is powerless to control.” *Id.* at 23. The First Circuit found this instruction to be “problematic” because immutability is not an automatic prerequisite for establishing an impairment. *Id.* at 23 n.7. The court nonetheless determined that the imperfect instruction was harmless error, since the jury had evidence showing that metabolic dysfunction was a permanent condition and that permanency, in this case, ran in favor of Ms. Cook. *Id.* at 24.

342. *Id.* at 23 n.7.

fatness and systemically held responsible for whatever consequences might stem from that fault. The underlying biases against fatness persist; the *Cook* decision maintains the position that people who can change their fatness should (and, arguably, must) do so.³⁴³

Further, the court held that regardless of the actual immutability of the condition, an employer's perception of an immutable condition will suffice to establish an impairment under the RHA.³⁴⁴ Though this vision of fatness played to the plaintiff's favor in *Cook*,³⁴⁵ the vision could have opposite results for many other fat people whom society perceives as simply lazy or lacking in will power. It may be easy for fat activists to see the appeal of the perceived disability theory; it provides a vehicle for showing that fatness is not necessarily a disabling condition even though society views it as such. It also provides a legal hook on which to hang a fat discrimination case when there may be an absence of an underlying impairment. Unfortunately, this betrays the normative point. Not all fat is bad or impairing,³⁴⁶ and a legal theory relying on the contrary narrow vision of fatness perpetuates the social perception of the falsity. Indeed, disability rights scholars and activists have offered a similar critique.³⁴⁷ The perpetuation of a vision that fat is bad simultaneously perpetuates collective cover-up of anti-fat bias, especially in the context of legal decisions that seem to advance fat rights.

Second, as to voluntariness, the court stated that the cause of the condition is likewise irrelevant to the decision of whether the condi-

343. See *id.* at 24.

344. *Id.*

345. *Id.* "[T]he jury reasonably could have inferred that [the employer] regarded plaintiff's morbid obesity as an 'impairment of a continuing nature,' . . . and that he rejected her application on that basis." *Id.* (quoting *Evans v. City of Dallas*, 861 F.2d 846, 853 (5th Cir. 1988)).

346. Some fat activists who adopt this position believe that disability law is an inappropriate venue for combating anti-fat bias. See generally SOLOVAY, *supra* note 11, at 129–33. They contend that achieving systemic "normalcy" depends on avoiding a vision of fatness as a disabling condition; fatness is not an impairing condition and should not need to be treated as such just to confront social norms. *Id.* Similarly minded fat rights activists believe that associating with another marginalized group will hurt the movement. *Id.* Certain members of the disabled community also oppose using the ADA to provide fat rights, wanting no association between disability and fatness, because they have worked to change the social construction of disability from disgust to respect; associating with fatness would, in their eyes, be a step backward. *Id.* Critical disability scholars, however, would likely disagree with the premises of these arguments, who conceptualize disability not as a transgression that disabled people should conquer, but instead "as a social and political force" to advocate for the advancement of disability rights. DORIS ZAMES FLEISCHER & FRIEDA ZAMES, *THE DISABILITY RIGHTS MOVEMENT: FROM CHARITY TO CONFRONTATION* 4, 13 (2001). Labeling fatness a disability, though it might be a convenient legal hook in certain circumstances, is not without controversy or negative consequences.

347. See FLEISCHER & ZAMES, *supra* note 346, at 13.

tion constitutes an impairment, but nonetheless pertains to the “substantially limiting” analysis.³⁴⁸

The Rehabilitation Act contains no language suggesting that its protection is linked to how an individual became impaired, or whether an individual contributed to his or her impairment. On the contrary, the Act indisputably applies to numerous conditions that may be caused or exacerbated by voluntary conduct, such as alcoholism, AIDS, diabetes, cancer resulting from cigarette smoking, heart disease resulting from excesses of various types, and the like. Consequently voluntariness, like mutability, is relevant only in determining whether a condition has a substantially limiting effect.³⁴⁹

Again, this language seems like a positive for disability protection of fatness, but upon closer scrutiny, it plays to the anti-fat bias running just beneath the surface of society, manifested through the legal system. In this way, the passage is somewhat misleading.

Voluntariness might not bear relevance to the origination of the impairment, but it does impact its continued existence, which, as the court noted, influences the determination of whether an impairment can be “substantially limiting.”³⁵⁰ In *Cook*, the court held that “the jury certainly could have concluded that the metabolic dysfunction and failed appetite-suppressing neural signals were beyond plaintiff’s control and rendered her effectively powerless to manage her weight.”³⁵¹ Fatness, in its usual depiction, can be managed if only fat individuals could control themselves (or so the rhetoric goes). According to mainstream anti-fat bias, fatness is not just caused by a voluntary action, but also perpetuated and maintained by continued choice.³⁵² The pervasive conception of body size choice precludes obesity from ADA coverage.³⁵³ The social norm dictates that people should be able to lose weight and keep it off, even if science dictates the opposite conclusion. So, collective cover-up emerges through voluntariness in two ways: the underlying impairment perpetuates the systemic vision that fatness is bad and inhibiting, and the “substantially limiting” analysis perpetuates the systemic vision that fatness is a choice, so fat people deserve whatever punishments they receive.

348. *Cook*, 10 F.3d at 24.

349. *Id.*

350. *Id.*

351. *Id.*

352. *See supra* section III.B.

353. Applying this construction to a different context, consider a smoker who develops a cough that could be alleviated through smoking cessation. Probably that cough does not constitute a disabling impairment. A choice to continue smoking and perpetuate the cough will not bring that cough within the jurisdiction of the ADA. If the cough develops into lung cancer, however, then the cancer is protected. It cannot be cured simply by quitting smoking. Similarly, if a person broke a leg skiing, let it heal, and the day after the cast was removed broke it again, the perpetual state of the injured leg still would not result in a finding that the person had a disabling injury.

Though the First Circuit provided relief for Bonnie Cook, the case laid the groundwork, through collective cover-up, for continued and legally justified anti-fat bias. Similarly, the ADA, Title VII, and the ACA demonstrate statutory collective cover-up of anti-fat bias, exemplified by the legality of health insurance fat taxes.

VI. CONCLUSION

If society wants to achieve its public policy goal of widespread health, then it should curtail counterproductive policies and programs that create, rather than remove, barriers to accessing the health care system. Legal health insurance fat tax programs³⁵⁴ do just that for a population that already faces numerous challenges within that system. Certainly others may disagree. Professors Kristin Madison, Kevin Volpp, and Scott Halpern recently voiced support for wellness and other “incentive programs” promoted through the ACA as a potentially useful method to “improve public health.”³⁵⁵ Specifically, they state that “[i]ndividuals often fail to take the steps necessary to improve their own health,”³⁵⁶ such as losing weight,³⁵⁷ and that “one advantage to an appropriately designed incentive program is that it can help individuals overcome the barriers they face in trying to avoid disease and disability.”³⁵⁸ They also state that distinctions in people’s abilities to conform to the requirements of the so-called incentive programs, such as food deserts³⁵⁹ and biological factors that might render thinness an unachievable goal, “do not necessarily imply that incentive programs impermissibly discriminate.”³⁶⁰ The analysis offered above, however, illustrates exactly that implication as a result of

354. See Yoshino, *supra* note 12, at 938 (“[T]he current [antidiscrimination] paradigm errs prescriptively in extending greater protections to those who cannot change, and errs descriptively in characterizing identities like race and sex as being incapable of any kind of change.”).

355. Madison et al., *supra* note 29, at 465.

356. *Id.*

357. *Id.* at 454.

358. *Id.* at 456.

359. See, e.g., *America’s ‘food deserts’*, THE WEEK (Aug. 12, 2011), <http://theweek.com/article/index/218167/americasquos-food-deserts> (defining a food desert as any census district where at least 20% of the inhabitants are below the poverty line and 33% live over a mile from the nearest supermarket).

360. *Id.* Stanford law professor Richard Ford agrees. See RICHARD T. FORD, RACIAL CULTURE: A CRITIQUE 134–38 (2005) (noting that weight-based discrimination might be unfair, “[b]ut there are good reasons that anti-discrimination law does not prohibit all ‘unfair’ discrimination, reserving what Brain [sic] Barry calls ‘the ponderous machinery of the law’ for the most pressing, pervasive and stigmatizing wrongs”); RICHARD T. FORD, THE RACE CARD: HOW BLUFFING ABOUT BIAS MAKES RACE RELATIONS WORSE 132, 159 (2008). But see RHODE, *supra* note 3, at 102, 104.

health insurance fat taxes, evidenced through fat covering and collective cover-up.

Perhaps new federal law that attends to collective cover-up would also generate improvements regarding individual covering. One possible method of addressing collective cover-up of anti-fat bias is through a new federal law modeled after state lifestyle discrimination statutes.³⁶¹ Generally, these statutes protect employees from discrimination based on off-duty “lifestyle” choices such as smoking, sexual relationships, or leisure activities.³⁶² These statutes essentially pit the employer’s business interests against the employee’s privacy interests, and declare a victor.³⁶³ The problem with this model for anti-fat bias, of course, is that it still relies on a systemic vision of fatness as a personal choice.³⁶⁴ Nonetheless, the model may provide a useful starting point.

361. See, e.g., N.Y. LAB. LAW § 201-d (McKinney 2009).

362. See generally Sugarman, *supra* note 4, at 418–20 (discussing statutes preventing various off-duty lifestyle choices from being considered in employment decisions).

363. *Id.*

364. See *id.* at 392.